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the mentally retarded child .....

..... a guide to services of social agencies

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CHILDREN'S BUREAU PUBLICATION NO. 404—1963

the mentally retarded child

a guide to services of social agencies

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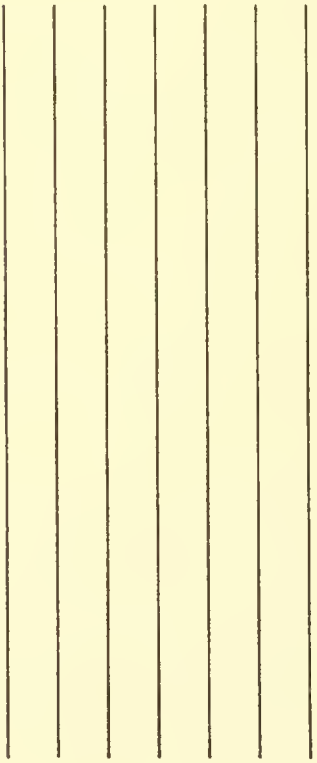
Specialist on Social Services
to Mentally Retarded Children



U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Welfare Administration • Children's Bureau • 1963

Foreword

On February 5, 1963 President Kennedy said, in a special message to Congress on Mental Retardation, ". . . I am proposing a new approach to mental illness and to mental retardation. This approach is designed, in large measure, to use Federal resources to stimulate State, local and private action . . . Emphasis on prevention, treatment and rehabilitation will be substituted for a desultory interest in confining patients in an institution to wither away."

These positive words of the President mark definitively our Nation's changed attitude toward those who are mentally retarded. For many years these persons were shunned or persecuted; they were not thought of as citizens with rights and responsibilities. Fortunately, social thinking has matured and, at present, focus is being placed upon these people—not as lost souls, but as persons who, with proper care and guidance, can be productive members of the community.

Recent emphasis on the idea that mental retardation is a problem having implications for areas other than the biomedical, calls for a broad approach to prevention and cure. The way is now paved for social workers and medical specialists to work together as a team in helping the mentally retarded. Heretofore, special social services needed in this area have been unavailable or lacking in quality. While budget deficits or staff limitations contribute to this situation, more often this lack of adequate services derives from a limited knowledge and understanding of the special problems involved and, consequently, lack of skill in applying social work methods and techniques to these problems.

The overall purpose of this publication, then, is to give social workers in training and in practice the information essential to providing better services to mentally retarded children and their families. To this end, the social aspects of mental retardation are stressed.

The Children's Bureau believes that all professional disciplines concerned with helping mentally retarded children attain their maximum potential will find much of value in this publication.

Katherine B. Oettinger

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Chief, Children's Bureau

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chapter I

AN INTRODUCTION TO MENTAL RETARDATION

A Look at the Past

FROM THE BEGINNING of history every society has been confronted with the problem of what to do with those of its members who are unable to meet the demands and expectations of its culture. (1)

The fortunes and misfortunes of the retarded—guided initially by superstition, ignorance and fear—date back many centuries. Most often these individuals were shunned, exploited, or persecuted. Sometimes their strange behavior caused them to be regarded as having supernatural powers. At other times, due to the compassion of religious leaders, they received kindly treatment. Seldom, however, were they looked upon as individuals with rights and responsibilities. Rarely were they thought of as persons deserving of help and capable of assuming a productive role in the community.

It was not until the 19th century that a significant beginning in the evolution of ***positive*** social thought toward the mentally retarded was realized. Sparked by the leadership of Itard, Seguin, Howe and others, scientific inquiry succeeded superstition and fear. Through the pioneering efforts of these leaders, sound educational and training techniques were developed to "cure" mental defects, and institutional facilities were established. These techniques, however, were applied largely to severely retarded persons—the major form of retardation identifiable at that time. And although program emphasis within the institutions was often merely custodial, a milestone had been passed in the acceptance of public responsibility for the retarded and the provision of humane care for them in public-supported facilities.

This perspective of what mentally retarded persons were like did not long endure. In the early years of the 20th century, public

attitudes toward the mentally retarded were profoundly affected by two scientific developments—intelligence testing and research relating to genetics. For the first time an instrument was available to measure the intelligence of a large proportion of the country's population and the public spotlight was focused directly on many persons whose behavior previously went unnoticed. Applied to army troops during World War I, these tests revealed an alarming number of mentally subnormal persons. In the harsh glare of this discovery mental retardation became recognized as a social problem of the first magnitude. The search for a solution to this pressing problem led in many directions and, inevitably, to a consideration of its eugenic aspects.

Practically all of the studies of the early 20th century—of which the Kallikaks and Jukes are best known—applied the rediscovered Mendelian concepts of heredity and the newly invented intelligence tests to an analysis of the families of mentally retarded individuals. Investigators reached the same conclusion: mental subnormality was transmitted through heredity. Some authorities—notably Tredgold—went even further, seeing retardation as an expression of various forms of deviation in the ancestors including insanity, epilepsy and other psychopathological states.

Perhaps the most alarming revelation was the extremely poor social behavior of the families studied. A high incidence of antisocial, immoral, and other unacceptable behavior traits, and higher than average birth rates, convinced many people that civilization was in jeopardy unless effective measures of control could be devised. The public image of the retarded is mirrored in the words of Dr. Walter E. Fernald—an authority in the field—in a speech made in 1912: (2)

> The social and economic burdens of uncomplicated feeble-mindedness are only too well known. The feeble-minded are a parasitic, predatory class, never capable of self-support or of managing their own affairs. The great majority ultimately become public charges in some form. They cause unutterable sorrow at home and are a menace and danger to the community. Feeble-minded women are almost invariably immoral and if at large usually become carriers of venereal disease or give birth to children who are as defective as themselves. . . . Every feeble-minded person, especially the high grade imbecile, is a potential criminal, needing only the proper environment and opportunity for the development and expression of his criminal tendencies.

To combat this alarming problem, some indignant citizens proposed that all defectives be put to death; others advocated restrictive

marriage laws; some of the more farsighted recommended a general improvement of the environment. Of the many recommendations made, control through life segregation and sterilization received the most popular support. Accordingly, many States embarked upon programs to detain indefinitely those defectives considered to be social risks and to sterilize those of reproductive capacity who could be returned to the community.

Concepts in change

The great depression of the 30's and World War II partially diverted the public's concern from the problem of mental retardation to more pressing economic, social and military problems. But in this war, as in the previous one, attention was called to the large number of retarded males in the population. In contrast to the early pedigree studies, there was no evidence that these men had had any trouble with law enforcement authorities. The vast majority (approximately 94%) had made a reasonable adjustment to civilian life. They were economically self-sufficient and socially responsible. (3, p. 81) (4)

The aftermath of the war again focused society's attention on the mentally retarded. Rehabilitation programs for disabled servicemen mushroomed, extensive educational campaigns urged employers to hire the handicapped, and new insights were developed regarding the remarkable restorative capacities of the human personality. Eventually, it was recognized that the mentally retarded, too, could profit from vocational training and placement programs.

Another factor contributing to changing public thought is the parent group movement, sparked by the establishment of the National Association for Retarded Children in 1950. Motivated to secure for their retarded children the rights and opportunities available to other children and essential to their development and self-fulfillment, Association members, including parents of retarded children, professional workers, and interested citizens, have stimulated public interest and activity.

Other national organizations, particularly the American Association on Mental Deficiency established in 1876, have shared this leadership role and have offered professional direction to expanding programs of care, training and treatment. Nor can one overlook the tremendous contributions of the U.S. Department of Health, Education, and Welfare through the research, training and service programs of its various operating agencies, its stimulus and technical assistance to State programs and its grants-in-aid. (5)

The most recent event of national significance in promoting services for the mentally retarded was the appointment by President

Kennedy in October 1961 of a Panel on Mental Retardation composed of experts representing citizen groups and a wide range of professional fields. The published report of the Panel—"A Proposed Program for National Action to Combat Mental Retardation"—represents a monumental contribution towards stimulating program development and advancing public understanding.

In its comprehensive analysis of factors relevant to mental retardation and in its survey of programs and resources in this country and foreign lands, false premises are attacked, important concepts are highlighted and new solutions to old problems are proposed. Three central themes permeate and guide the report: (1) retarded persons have potentials for productive living beyond those heretofore recognized, (2) responsibility for the mentally retarded must be shared among the Federal, State and local governments and voluntary groups and organizations, and (3) a real possibility exists of preventing mental retardation on a large scale through a broad assault on adverse environmental conditions in our society.

The proposed blueprint for action includes over 100 recommendations. Many dimensions of the problem are embraced: research; prevention; clinical and social services; education; vocational rehabilitation and training; residential care; legal aspects; planning and coordination of services; public awareness.

Considering the restrictive character of the laws governing the mentally retarded in many States today, the Panel's discussion of this element is both refreshing and forward looking. Guided by the philosophy that law is not a substitute for services and that mandatory and coercive legal action should be kept at a minimum, recognition is nevertheless made of the need for special protections for the retarded. Particular attention is directed toward the protections needed with respect to guardianship, admissions to institutions, and responsibility of the retarded under criminal law.

What Is Mental Retardation?

Mental retardation, because of its complex social, medical, psychological, legal and educational components, is one of the most difficult problems to understand and define.

From an *educational* point of view, mental retardation is a condition of subaverage intelligence that limits a child's capacity to profit from regular classroom instruction. The IQ is the major criterion used in evaluating the child's learning ability as a basis for selective school placement. For this purpose, it has real practical value.

However, performance on intelligence tests or poor achievement can be affected by many variables: *cultural background, degree of mental stimulation in the home, motivation for learning, and emotional disturbance.* Even the academic expectations of schools—which vary with the socio-economic and cultural aspects of the neigborhood—help to determine who is identified as mentally retarded.

With primary emphasis on IQ and ability to assimilate the subject matter of the regular curriculum, school authorities may identify as retarded many children who adjust satisfactorily in the home and community and are not considered subnormal by their peers. Children of a given mental ability will be looked upon as mentally retarded in one setting and as near the norm in another. Further, the same child during his school career may move in and out of the retarded category and discard the label entirely upon entering the industrial community with its relatively lower requirement of intellectual skills.

In the framework of *social-legal* definitions, the mentally retarded refers to those persons who are socially incompetent and intellectually subaverage to the degree that "they cannot manage their own affairs with ordinary prudence and judgment" and either need protection or are a threat to the safety of others.

Whereas there is fairly common agreement that these components are proper to a definition of mental retardation, much confusion exists as to how much intelligence (as measured by objective tests) is required to meet life's demands and what constitutes social incompetency. Some States for example, in certifying an individual for admission or commitment to a State institution for the retarded, arbitrarily exclude persons with IQ's above 70 or 75. On the other hand, administrative policies in other States place less emphasis on the IQ and accept persons whose major problem is one of social deficiency. However, standards of what constitutes satisfactory social behavior are arbitary and subjective to some degree, and differ between societies, and in a given society at different times.

While mental subnormality by itself cannot be looked upon as an adequate criterion of mental retardation, overemphasis on the concept of social inadequacy, or sole reliance upon it, is fraught with even greater danger. If the behavioral aspects of the problem are considered alone, without regard to intelligence level, mental retardation is likely to be confused with other mental disorders. Under these conditions, neurotics, delinquents, character disorders and disturbed persons could be classified as mentally retarded. This is scientifically unsound and tends to further complicate group training and treatment programs, already complicated by the extreme heterogeneity of the populations to which such programs must be geared.

Definitions of mental retardation sometimes include biological factors, as reflected in the terms "arrested development" and "rate of

maturation." For medical purposes, the underlying disease processes or medical conditions which result in mental retardation are all important. But the presence of pathological defect in some retarded persons in no way negates the social aspects of mental retardation. Those who equate cerebral defect with "true retardation," overlook the symptomatic nature of retardation and place undue emphasis on etiology. The child who fails to measure up to expectations because he has been deprived of the essentials for normal development may be just as handicapped as the child who has suffered some form of cerebral injury. Potentials may differ, treatment needs may vary, and the symptom may be less subject to change in the latter instance, but such variations between these two groups and between individuals within each group, do not preclude a single definition.

Current definitions

Many definitions of mental retardation in use today lack preciseness. When these definitions are too general they may be loosely interpreted and, too often, improperly applied.

These difficulties are perhaps best met in the definition and classification system recently proposed by the American Association on Mental Deficiency (6), which states:

> **Mental retardation refers to subaverage general intellectual functioning which originates during the developmental period and is associated with impairment in adaptive behavior.**

A vital factor in this definition is the recognition that the characteristics of mentally retarded persons cannot be reflected by any single system of classification. A low IQ alone does not satisfy the criteria in the definition. Neither does social incompetence or a learning disability signify mental retardation, for these are frequently a function of personal-social inadequacies. Only as deficiencies are demonstrated in both areas—adaptive behavior and measured intelligence—can the individual be called retarded.

These two elements in mental retardation are not completely independent. Generally, the individual of limited intellect will encounter some difficulty in adapting to the environment, at least during that period of his life when learning is at a premium. But intelligence tests only predict some aspects of behavior, such as abstraction ability, verbal skills, and potential for academic achievement; they are less reliable in predicting an individual's capacity to meet the problems of daily life. Among mildly retarded adolescents and adults, discrepancies between levels of intelligence and adaptive behavior frequently occur. This observation has particular significance for

workers in social agencies who are apt to encounter many mildly retarded persons among the disadvantaged families that constitute the major proportion of their clientele.

It should be noted, too, that an individual's performance on objective intelligence tests does not indicate any potential or absolute level of mentality, but measures only his *current* level of intellectual functioning. Implicit in this statement is the concept that the IQ is not a stable quality, predetermined at birth. On the contrary, the rate of mental growth in a child and the ultimate level he achieves are influenced, in many instances, by his experiences, particularly during the early years of his life.

Despite the excellent progress made thus far in defining mental retardation, the task of applying the definition to individuals must await refinement in our measuring instruments and diagnostic skills. Intelligence tests in their present form are considered by many authorities valuable tools, but tools which are unequal to this complex task. (7) Failure to eliminate cultural bias and a limited assessment of the broad range of human abilities and aptitudes are some of the inadequacies commonly noted. And what is true for intelligence tests is equally true for measurements of adaptive behavior. A good beginning, however, has been made in the functional descriptions of adaptive behavior contained in the previously noted manual of the AAMD. (6, p. 63)

Mental retardation then, is not a disease entity but a constellation of symptoms which derive from many causes, some inherent in the individual and others environmentally induced or determined. For the most part, it is manifested in the preschool child by a lag in maturation, in the school age child by a learning disability and in the adolescent or adult, by social inadequacy. In the majority of instances all three areas of impairment are evident. In all cases there is subaverage intellectual functioning.

None of these impairments are necessarily unalterable characteristics, particularly in those cases where there is no central nervous system damage. The level of *mental performance* in a child is determined at least in part by his basic potentialities, the intellectual stimulation he receives, his motivation for learning and his educational and cultural opportunities, particularly at certain crucial periods of development. His *social performance* stems not only—and perhaps not even primarily—from his limited judgment, but is also conditioned by the child-rearing practices of his family, the nature of his interpersonal relationships and his total range of life experiences.

Both of these dimensions by which mental retardation is defined are subject to change in many cases through education, training and

treatment. Skillfully applied, these services can accelerate a child's rate of mental growth or, failing in this, can help him to function in a more socially acceptable manner.

Causation

The causes of mental retardation are a complex and controversial subject, encompassing the sciences of genetics, biology, medicine, psychology and sociology. Various broad systems of classification are used, but one of the most simple and meaningful distinctions proposed especially for purposes of the social worker, relates to the presence or absence of central nervous system pathology. The child with organic or pathological defect differs in significant ways from the neurologically intact, non-organic, culturally retarded child. The former is usually more severely retarded, is more likely to have a physical disability and generally has a lesser potential for social and vocational independence. In many respects the families differ too, for whereas the parents of the organically damaged child may come from any segment of the population, the parents of the subculturally retarded child are almost always among our most disadvantaged groups.

As is true for most generalizations, exceptions do exist. The overwhelming majority of children of very low intelligence (below 50 IQ) have some cerebral abnormality, but the presence of such abnormality does not preclude mild retardation or borderline intelligence. Similarly, the child who is socially and culturally deprived is not immune to further debilitating disease processes nor is the brain-damaged child free from social hazards. Neither group is a distinct and pure entity, but the separation of the organic and non-organic into broad etiological categories is a useful way of breaking down this highly complex subject into more manageable and more understandable components.

Organic defect

More than two hundred known diseases and conditions can result in some degree of mental retardation involving central nervous system pathology, and many are still to be differentiated. Most of these are extremely rare with only a small proportion occurring with sufficient frequency to have practical importance. Actually, cases of organic defect comprise in all, about 15 to 25 percent of the mentally retarded population.

A large majority of organic defects are prenatal in origin.

Some conditions—a small minority—are transmitted through hereditary mechanisms, and genetic factors determine the form of abnormality. Among these, some of the best known relate to inborn errors of metabolism, of which phenylketonuria and galactosemia are prime examples. These conditions are quite rare (PKU occurs about once in every 26,000 live births), but the advances in our understanding of the mechanisms by which the brain is injured through those disorders have resulted in methods to prevent retardation in these children. The eugenic implications of research in this area are important too, for through the development of mass screening and detection techniques, the parents who carry these genes may be properly counseled.

Certain disease processes, usually occurring during pregnancy, have also been implicated in the production of brain pathology and mental retardation. German measles during early pregnancy, congenital syphilis, toxic agents, and other infectious diseases are examples. Jaundice of the newborn, resulting from RH blood factor incompatibility and lead poisoning are other known causal agents.

In a minority of cases, organic defects occur during or after birth. The child's brain may be injured through a difficult instrument delivery, by other complications of pregnancy or delayed breathing. Or he may be damaged by viral or bacterial infection or a severe blow to the head.

One of the most common types of organic defect is mongolism. On the basis of recent investigations, it is now believed that this condition stems from abnormal arrangement of chromosomes, at about the time of formation of the ovum in the mother. The reasons for this abnormality apparently differ. Among older mothers—generally over 35 years of age—the problem may be related to a declining efficiency of the reproductive system. In a proportion of younger mothers, however, the chromosomal abnormality is apparently hereditary in nature (a small percentage of all mongoloid births). The distinction in causes is highly significant, not for the child, but for its genetic implications.

Detailed knowledge of the many specific etiological factors which result in organic defects among retarded children—only a few of which have been identified—is generally not required by social agency personnel. The determination of causes is essentially the responsibility of the medical practitioner but the social worker may contribute to this objective by the collection of pertinent information. An understanding of the *kinds* of causal agents involved, however, can be very useful to social workers whose clients are members of low income families and are often especially vulnerable to these processes. It may alert these workers to the importance of good prenatal, obstetrical and pediatric care, and to their role in seeing that these services are not only made available but are used by the client. In

specialized settings, the social worker may wish more detailed information on causation. For these persons, more extensive data are available (8) (7).

Non-organic and cultural defect

Various theories have been proposed to account for retardation in individuals who have no demonstrable brain damage insofar as we can tell with our present instruments. The causes of retardation in this group are as yet, incompletely understood. Some members within this large category (75 to 85% of the total retarded population) are believed to be products of complex mechanisms of heredity. Their retardation is assumed to stem from the fact that human beings show genetic variability in any characteristic, including measured intelligence. The prevalence of this type of retardation in the lower socio-economic groups in our culture, however, strongly supports the role played by environmental factors as well. The psychological circumstances of life, interpersonal relationships, social interaction and growth-promoting experiences are definitive or contributory factors. Conditions unfavorable to health, to which mothers in these families are particularly subject, may also produce *undemonstrable* brain damage. Thus, these factors may represent a contributory element to the low intelligence of some of the children currently classified as being without central nervous system pathology.

The source of retardation in individuals who have no organic defects—demonstrable or undemonstrable—is best explained as due to the complex interaction of genetic factors, psychological experiences and environmental influences. All of these operate more strongly in the underprivileged groups of society, and while few would dispute the role of "nature" and "nurture" in this type of retardation (cultural-familial), the *relative* importance of each is still a matter of much debate.

The theory proposed by some—that every child, in the absence of pathological defect, has the same intellectual potential as every other child and that his development is entirely a result of his experiences—does not seem tenable. Nor is the converse—that mental abilities are rigidly predetermined at birth—any more acceptable.

A reasonable and highly supportable formulation of the nature-nurture controversy has been offered by Hebb. (9)

> There are two determinants of intellectual growth: a *completely necessary* innate potential . . . and a *completely necessary* stimulating environment. It is not to the point to ask which is more important; hypothetically, we might expect that intelligence will rise to the limit set by heredity *or* environment, whichever is lower. Given a perfect environment, the inherited

constitution will set the pace; given the heredity of a genius, the environment will do so.

The unfavorable social condition in which subcultural defectives invariably live, obviously does not provide the "completely necessary" stimulation for optimal growth. Lack of affection, individual attention and intellectual stimulation, particularly in infancy and early childhood, can seriously retard mental growth. In some cases the mentally limited mother, already taxed by homemaking and other responsibilities and preoccupied with personal needs, may regard her retarded child as an unnecessary burden and deny him the emotional security that comes from fondling and caressing. Lacking knowledge of the needs of her child and how to meet them, her reactions may be inappropriate, confusing and punitive. She may not fully understand the importance of cleanliness, correct feeding or medical supervision and perhaps unwittingly contribute to his neglect in these areas. Equally important, she is unlikely to stimulate her child's language abilities or motivate him to learn.

This description is not wholly applicable to all retarded mothers, nor is it limited to this group. Many parents of normal intelligence exhibit similar deficiencies and many subculturally retarded children, though they may lack mental stimulation and growth-promoting cultural opportunities, are not emotionally or morally neglected.

The most vital considerations regarding psychological, social and cultural deprivation as causal agents in mental retardation—and of greatest import to social workers—is the reversibility and preventability of such defects. Studies of children in adoptive placement indicate a marked difference between the intelligence of the children and their natural parents, particularly the mothers. In a noteworthy study by Skeels and Harms (10), children of mentally limited mothers and from relatively inferior socioeconomic backgrounds developed far beyond the potentials that would have been predicted from the intellectual, academic and occupational achievements of the true parents (to a mean IQ of 117). The fact that these children were able to measure up to the expectations of adoptive parents with high educational and cultural standards has important implications for social work practice. It has particular relevance to the adoption policies of public agencies to whom children with such backgrounds are likely to be committed.

Other researchers have cited anthropological evidence which suggests that people in primitive societies function on a level comparable to the subnormal in advanced cultures, though no genetic inferiority can be demonstrated. Studies of social and ethnic groups show marked differences among the members of these groups, which are best explained in terms of cultural variations and educational

opportunities. An excellent and highly detailed consideration of anthropological and other studies bearing on the issue of cultural deprivation in the causation of mental retardation is contained in *Mental Subnormality.* (7) (For another comprehensive and analytic review, see Sarason 11.)

Many studies, particularly those upon which Bowlby has reported, support what we have known for many years—that children need stimulation, attention, affection and "mothering" if they are to realize their fullest potentials. (12) When they are deprived of these, growth is stunted, sometimes to the extent that complete recovery is not possible. (13) (14)

The work of Goldfarb is important in this connection and worthy of note because of the overriding tendency of professional workers to advise institutional care for young retarded children. (15) Comparing a group of children brought up until the age of three in institutions and then placed in foster homes with a control group of similarly endowed children placed in foster homes from infancy, he found a consistently poorer development among those who had been in institutions. The average IQ of these children was more than 20 points less than the control group and they were inferior as well in their social and emotional adjustment. The notion expressed by this investigator that it is not group care as such, but rather the lack of individualization (a difficult thing to achieve in most large institutions) that is so detrimental to the child, is supported by other studies.

From the evidence available, we may reasonably conclude that in defining the causes of non-organic and cultural defect, a sharp distinction cannot be drawn between an individual's innate capacities and the impact of the society in which he lives. Each individual continuously interacts with his surroundings, being affected by it and in some small measure affecting it in turn. The cultural defective, like other retarded persons and like normal persons as well, is part of this social process.

chapter II

THE MENTALLY RETARDED CHILD

Factors in Development

ALTHOUGH there is general agreement on the factors influencing development—heredity, physical environment, and social environment (16)—opinions vary widely as to their relative importance, how they interact, whether certain ones are innate or acquired, and the degree to which the development of the child can be controlled or modified. In the clarification of these concepts, we may find many clues as to what we must look for in sharpening our diagnostic formulations, in determining what type of treatment is indicated and what changes may be anticipated.

Biological endowment

Every child embarks upon his life experiences with certain constitutional attributes and potentialities. What the child "is" and what he may become is clearer as his range of abilities expand and more precise instruments become available for measuring these abilities. On the other hand, the greater his exposure to environmental forces, the more difficult it is to distinguish what is innate and what is acquired.

The original endowment of the retarded child is in all instances *somewhat* dependent upon the genes he inherits from his parents. In some instances genetics are relatively unimportant and disturbances in fetal development or injury or infection during or after birth are primary determinants. In still other situations, the child's original biological capacities and neurological system are affected by poor nutrition and health conditions or by damaging psychological experiences with associated somatic effects.

The presence or absence of central nervous system pathology

and the degree of involvement are crucial factors in development. Although the development of all children is influenced in some measure by external forces, the growth potentials of the child with cerebral defect are more circumscribed than thoses of his retarded, but neurologically intact, counterpart.

The many differences between the organically defective and the organically intact retarded child have prompted some authorities to advocate differential terms—mental deficiency and mental retardation, respectively—to distinguish between these two broad categories. But even where a group of individuals belong to a relatively "pure" category, uncontaminated by those forces which characterize the other group, significant variations exist among them which caution against overgeneralization.

Children with gross cerebral defect—whether due to tissue injury, malformation or arrested development—frequently have associated physical defects. The symptom of limited intelligence in these children is only one manifestation of insult to the total system. The more severe the defect, the greater the physical inferiority as a rule, and the slower the rate of growth. The correlation between physical *abnormalities* and mental growth, however, is of lesser import, except in some clinical types such as mongols, microcephalics and certain endocrine disorders.

Physical defects in severely handicapped children are important factors in their development and of great concern to parents. Among these, sensory defects, particularly in vision, hearing, and motor skills, are extremely common. (8, p. 157) Frequently these disorders go undetected and the child's performance is thought to stem from a mental defect when in reality his handicap is physical in nature. Such errors in parental or professional diagnosis can be very damaging. Handling of the blind or deaf child as though he were mentally retarded and failure to provide learning experiences to compensate for the loss of these senses may actually result in mental retardation if continued over a prolonged period of time.

There is a tendency to relate specific characteristics of behavior and personality to certain clinical types or a vaguely defined category of "brain-injured" children, without allowing for individual variation. For example, microcephalics (small head circumference—severe to moderate retardation—considered to be transmitted as single recessive gene) are often described as highly distractible, quick and active in movement and severely retarded. Phenylketonurics are said to demonstrate the same kind of behavior and level of intellect, to have a short attention span and to be pleasant and affectionate.

Generalizations of this kind derive from years of observation and study and cannot be lightly dismissed. Although there are exceptions, these generalizations do in fact offer a fairly sound basis for

predicting physical and intellectual growth potentials (though not personality characteristics) of many of these children. Most, but not all, microcephalics are hyperkinetic in their movements. Most, but not all, PKU's (phenylketonurics) are severely retarded; in a few rare instances they have near-normal intelligence. To further illustrate, children with epilepsy frequently are impaired mentally and some have behavioral disturbances, but a high proportion are normal in both of these respects. Many "brain-injured" children are profoundly retarded or in the lower ranges of intellectual ability, but such injury, particularly where it is of minimal degree, precludes neither mild retardation nor average intelligence. Some organic disorders, in fact, are known to cause behavioral difficulties and learning problems in many school age children of adequate mental endowment.

These observations suggest that precautions need to be taken in predicting adult status on the basis of an individual's development in early childhood. Nevertheless, the capacity for physical and mental growth is considerably constricted in certain clinical conditions. Knowledge of the biological endowment which characterizes these conditions can be of great value in helping parents with problems of care and management. *Applied with caution and safeguarded by careful observation and periodic reevaluation, such information can be highly useful.*

Perhaps the most common misconceptions apply to the mongoloid child. Though it is true that many of these children have a happy and cheerful disposition, are affectionate and easily amused, are fond of music and have an aptness for rhythm, these traits are by no means universal or inherent. The mongoloid child in fact presents as wide a range of personal qualities as do other retarded children. He may be sulky and uncooperative, prone to temper tantrums, irritable, disagreeable, demanding. His temperament is not wholly a reflection of his biological endowment but is due instead to the interaction of constitutional and environmental factors. Perhaps because of his cherubic appearance and the relative ease with which he can be cared for (compared to other types of handicapped children) he evokes favorable responses from adults that help mold the kind of personality he often reveals. The physical resemblance of mongols to one another does not guarantee similarity in personality.

The patterns of mental growth in mongoloids, however, do show some significant pecularities that distinguish them from other retardates and normal children. Growth is irregular; prior to school age, many mongoloid children function on a level of mild retardation. They seem to reach a plateau in early school age, however, and the rate of mental growth then declines to a point of performance usually in the range of moderate and sometimes severe retardation.

Comparisons between mongoloid children living at home and those in institutions tend to show the former superior, not only with respect to mental abilities but in social and emotional maturity as well. Here, too, the ultimate development of the child depends in some measure on the nature of his life experiences. Biology sets the upper limits—rarely, if ever do mongoloids have average intelligence—but the environment, broadly conceived, usually determines whether these limits are realized.

Few problems in mental retardation have attracted more attention that those exemplified by the brain-injured, so called "exogenous" child. The term has been vaguely and variously defined and in common usage refers to a wide range of conditions and causal agents. Children in this group differ considerably from each other in all areas of measurement, yet certain traits appear with sufficient frequency to make descriptive generalizations meaningful and sometimes of diagnostic value.

Parents of brain-injured children—who may range from severe defect to average mentality, depending in part on whether there is malformation of the brain, a developmental defect or an acquired injury or infection—often face serious problems of care, supervision and management. Some of these children are completely dependent and helpless, placid and unresponsive. Others are hyperactive, aggressive and destructive, prone to violent outbursts, irritable, impulsive, difficult to control. Commonly—as a result of or concomitant with such organic impairment—there are sensory defects, motor handicaps and disturbances in perception, thinking and emotional behavior.

These physical attributes and behavioral patterns are constitutional in origin, but they are often reenforced by experiences of failure and frustration. In the home, aggressiveness prompts hostility in the parents and still more aggression in the child. In the school, teaching techniques which do not recognize perceptual disorders or sensory impairments, intensify problems of learning and adjustment. In the community, ridicule by age mates of the child whose motor coordination makes him inept at riding a bicycle, skating, or catching a baseball, aggravates his behavior.

The innate intelligence of retarded children without pathological defect is, as we have earlier noted, uncertain. On the basis of current evidence, however, it would appear that while biology sets the upper limits, these limits are not severe. Parents with limited intelligence or other mental abnormalities, are less likely to produce offspring with better than average intelligence and will produce a larger proportion of dull children than is to be found in the offspring of "normal" parents. But many of their children have potentials for average development. That these potentials are frequently unreal-

ized, seems to be attributable in many instances to the early adverse environmental experiences to which these children are commonly exposed.

The physical inferiority of severely retarded children can be traced in many instances to the same neurological defects that cause their mental disability; logic would dictate therefore, that in the absence of such defects, the physical abilities of the retarded—manual dexterity, motor coordination, sense perception—would be comparable to those of normally intelligent children. Observation of the culturally defective tends to support this. Though they furnish few of our outstanding athletes and skilled technicians, these children are able to perform many tasks requiring good manual ability. Their physical inferiority, if any, is slight. The common observation that many of these individuals have "weak bodies" as well as "weak minds" (in contrast to the "strong back, weak mind" adage) does not mean that these deficiencies are constitutional in origin. More than likely, deprived socio-economic circumstances are responsible.

Physical forces—action and interaction

In the crudest sense of the term, most children are reared in an external environment that does not change dramatically. Their basic needs for physical, mental and social development are adequately met, they are not exposed to highly traumatic, permanently damaging emotional experiences, and they are not afflicted by diseases of a severely disabling nature.

Retarded children, notwithstanding their extreme heterogeneity, are more likely to be subject to inconstant or less favorable environments. The reasons for this derive in part from the common characteristics of these children, mental subnormality and social incompetency, and the reactions these evoke from parents, siblings, teachers, age mates and others. For a certain segment of the retarded population at least, this is also due in part to associated physical handicaps and sensory defects. For the culturally deprived child, the environment may be relatively constant, but constantly unfavorable. Some of these forces can be loosely defined as physical; they include, in part, general living conditions, disease, nutrition, and the handling and perception of objects.

Obviously, the complex physical and social forces which affect the retarded child's development are not limited to him. Any child would be vulnerable to these forces but similar negative experiences may be more damaging to retarded children, because of their limited compensatory skills, than they would be to others. Equally important they may occur with greater frequency among this group than in the population as a whole.

Physical defects, especially of the sensory type often interfere with or seriously restrict learning experiences. The significance of this observation is most clearly seen in children with severe impairments in sight or hearing. The experiential world of the blind child is bounded by what he can hear, touch and smell. If he has been blind from birth or from an early age, he may never grasp the concept that red is a warm color or that glass is transparent. He may never understand what constitutes beauty of shape or form, what a horse really looks like and that the sky is blue and filled with stars. The limitation that lack of sight imposes upon learning—a capacity both determined by intelligence and influencing its development—is obvious. It explains why many blind children lag behind in their mental growth and in fact are often misdiagnosed as mentally retarded.

More important perhaps than the limitations on learning, are the psychological and social limitations. Children are guided in their social relationships by many visual cues. When these are denied to them they may develop an insensitivity to certain kinds of social stimuli, and social participation—particularly through play activities—may be greatly restricted. In childhood, play is an important factor in a child's social status and has considerable bearing on his social intelligence and personality. Denied normal opportunities for social expression, the blind child may well develop strong feelings of inferiority, self-deprecation, withdrawal and undesirable behavior patterns.

Similar considerations apply to the retarded child with other sensory defects which, though not as apparent as in blind or deaf children, are equally dramatic in their effect on overall development. The child who is confined to his crib, to his home or to his back yard, is necessarily limited in what he can explore, handle, see, do. Moreover he can learn little about social intercourse with his peers if his total experience has been with his parents or other adults.

The retarded child who has difficulty in getting around, has poor motor coordination, a speech defect or other impairment, needs to have the world brought closer to him, if the converse is not possible. The damaging effects of sensory deprivation are potentially great, but they are not inevitable. The child with a severe motor handicap will never learn to crawl or walk if he spends all his waking hours in bed. He will not learn to talk if he is not spoken to or if his needs are always anticipated, making verbal communication unnecessary. Neither will he learn to swim on dry land, play baseball by watching, learn to share by solitary play. Invalidism that is unnecessarily prolonged or social isolation unthinkingly enforced, is unhealthy. Children who cannot think well are especially in need of sensory stimulation. *Opportunity to enjoy a wide range of physical experiences*

is essential, not only for the obvious beneficial effects in physical growth, but for its effect on learning and its consequent impact on psychological and social development.

Physical aspects of the environment may be regarded in still another context. The retarded child, who by happenstance of birth is a member of a socially and economically deprived family, is in many respects a victim of his environment. Social workers are fully aware of the possible effects of low income and social status on family integration and the physical and social well being of children. But even where the emotional climate in the home is comparatively wholesome, the lack of material resources can be very damaging. Poverty has many concomitants—a higher incidence of disease and impairment of general health; overcrowding and inadequate sleeping space; dietary deficiencies; absence of play space; lack of intellectual stimulation.

All of these factors are hostile to growth. The fact that millions of children of normal intellect are similarly impoverished is not a refutation of its importance in child development. On the contrary, it suggests that many underprivileged youngsters have unrealized potentials and that our human resources are not being fully exploited. In many instances a general betterment of the environment will stimulate the development of healthier bodies, minds and personalities. This does not imply that a healthy body is a guarantee of intellectual growth. It does suggest, however, that illness and disease can be serious handicaps to the utilization of intelligence and may also have a direct bearing on social and emotional adjustment.

Social forces

An important concept in child development is that the rate of intellectual growth can be changed—up or down—by altering the child's life circumstances. Among these life circumstances, none are more crucial than those encountered within the family circle. For it is within the family that the child is directed from the "self-centeredness" of infancy toward the "social-mindedness" more characteristic of later life. Here he learns right from wrong, respect for property, consideration of others, how to share. Here are planted the seeds of social usefulness and adult responsibility. Here are established the foundations upon which social institutions outside the home must build, if full growth is to be realized.

The relevance of this concept to retarded children is clear. Indeed, the impact of intrafamily relationships on the mental growth and behavior of the retarded child is particularly vital, for it may not only raise or lower performance but may determine in some instances whether the child is or is not to be classed as retarded.

To workers in the field of mental retardation or other handi-

capping conditions, it is a commonplace that a handicapped child is a threat to family stability. The stress created by the presence of such a child often results in a distortion of relationships and an environment that differs in many respects from that to which the intellectually normal child is exposed. This does not mean that family pathology is an inevitable consequence of retardation, nor that it will endure so long as the child remains in the home. Many families, in the course of time, muster their psychological resources, readjust their living patterns and provide a healthy climate for growth.

A fairly safe assumption, however, is that in the overwhelming majority of families (where the child's defects set him apart from other members), the initial reaction of parents to the knowledge of their child's deficiency will be traumatic. Often this reaction will be harmful to the child as well. In case of gross retardation, such knowledge comes early in the child's life—at a time when maternal affection, acceptance and guidance are most essential. Mothers—and fathers too—burdened with feelings of disappointment, sorrow, frustration, anger, anxiety, hopelessness and guilt, have difficulty in being the kind of parent to their retarded child that they are to their other children.

In a culture that places a premium on high intelligence, social status and prestige, the retarded child is apt to be regarded as a liability and a potential threat to family goals and aspirations. The disturbed feelings of parents that arise under these circumstances should, in most instances, be looked upon as normal reactions to an intensely frustrating, ego damaging experience. Community and professional understanding of this fact is a first step toward improving the home situation, but it is only a beginning. Unless skilled services are provided before these reactions become crystallized, the social milieu of the home will not only fail to promote, but will suppress, development.

Families of retarded children frequently do not observe sound child-rearing practices in regard to their retarded child. Though handicapped children by virture of their limitations need more protection than normal youngsters, the natural concern of parents in this regard often takes the form of extreme oversolicitousness. Children who have things done for them that they can do themselves, or who are denied responsibilities they are able to assume, or who are needlessly protected against the consequences of their behavior, have little chance to grow. Physical or sensory handicaps are reenforced when there is lack of normal practice in acquiring new skills. Isolation from other children and restricted play opportunities prompted by parental concern for the child's safety, are deterrents to social maturity. The retarded child's greater dependency sometimes causes him to be infantilized beyond the dictates of reality. And if the

child, because of his handicap or behavior, or because of adjustment problems within the family, is institutionalized at an early age (a sometimes necessary plan), the problem of emotional deprivation may be added to the physical and mental defect.

The critical impact of social forces on the development of retarded children and its relatedness to etiology has been clearly demonstrated in an experimental study by Kirk. (17) The findings of this study strongly support the need for intellectual stimulation of young retarded children and have emphasized the significance of the family environment. Children studied who lived in psychosocially deprived homes and who did not receive mental stimulation outside the home (through preschool education) remained at the same rate of development or dropped to a lower level. Conversely, the majority of siblings of these children who attended preschool were able to compensate to some extent for the socioeconomic inadequacy of their homes and accelerate their rate of growth. Where the inadequacy of the home was due to restrictive child-rearing practices and uncooperative families, it was more difficult to promote change than in homes where training was consistent and the parents interested.

Social forces affecting development are not confined to those of the family circle nor limited to the preschool age child. The time must come when the child extends his scope of activities and relationships and leaves—for part of the day at least—the relative security and semiprotective atmosphere of the home. In the larger community, the retarded child is particularly vulnerable to social pressures and to attitudes that are sometimes uncompromisingly hostile.

Society's attitudes toward the mentally retarded—prevailing but not universal, and more commonly applied to the cultural defective than to other segments of the retarded population—stem from our great emphasis on economic success and intellectual achievement. Many of our important social institutions, of which the school is a prime example, are directed toward this goal. We expect people to be literate, to support themselves, to be moral and law-abiding, to compete, to handle their own affairs with ordinary sense and judgment.

Retarded persons are not wholly deficient, or deficient to the same degree, in measuring up to these social expectations. The expectations themselves, however, not only help to define who is mentally retarded, but are part of the broad spectrum of social forces that color the retardate's concept of himself and his perception of society, and thereby influence his development.

Normal children have many opportunities to enhance early development by social-personal interaction with peers. They learn from, stimulate, and motivate, each other toward self-improvement and greater achievement. Even the less capable among them fre-

quently have a special skill or talent that encourages continued participation in group activities.

Retarded children by comparison—because of the psychological isolation often imposed upon them by peers—are denied these growth opportunities. They are the children most frequently identified in sociometric studies as the rejected, lonely ones. Extreme forms of isolation are known to cause marked deviations in thinking, feeling and action. (18) Children deprived of affectional relationships with teachers and peers or other enriching human contacts, are not likely to think well of themselves or to regard with kindess those around them. Little wonder that the retarded sometimes act out their resentments or withdraw from these painful experiences! Little wonder that a major objective of rehabilitation services for young adult retardates is to strengthen their skills in social relationships!

Illustrations regarding the impact of social forces, and their potential disintegrating effects on overall development, could be drawn for every age level. The agency or individual who attributes all social misconduct on the part of the retarded to low intelligence per se, the employer who regards the retarded as undependable and unreliable, the social institutions that demand more than can be reasonably expected—all contribute to a sense of failure and an unflattering "self-image" that inhibits maximum development.

Growth and Behavioral Characteristics

The growth and behavior of retarded persons is understandably a matter of grave concern to parents. Whereas the parents of normal children have many standards against which to measure and compare the development and behavior of their children, similar guidelines regarding the retarded have not yet been clearly formulated. Indeed, a single timetable to encompass the extreme conditions in this broad diagnostic category would not be meaningful.

Because of this lack of guidelines, even for subgroups of the retarded population, parents receive little direction in estimating a child's future status and capacities. Baffling questions frequently arise to which answers of a general nature may be of little help, or perhaps inappropriate. Parents will ask: How much responsibility and what kind of tasks can I reasonably expect my child to perform, and when? Will he be able to get along with others? Is he apt to become involved in sexual misconduct or delinquent behavior when he reaches the age of adolescence? Will he need constant protection and supervision?

The way children adapt to the demands of their environment and the defense mechanisms they employ to maintain some balance

between inner needs and external pressures is determined not only by their physical capacities and emotions, but by their intelligence as well. The severely retarded child reacts on a fairly elemental level to pleasurable or painful experiences. His behavior is not a conscious effort to please others, for he cannot comprehend the "give and take" of interpersonal relationships. While the child may show some responsiveness to kindness and attention, much of his behavior is random, impulsive and nongoal directed, compared with the behavior of persons with higher levels of functioning.

As the capacity to think and reason increases, the range of adaptive responses to the environment increases too. As a rule the milder the retardation, the closer the behavior approximates that of normal persons. Actually, the growth and behavior patterns of children with mild or boderline retardation differs considerably from those of children at the lowest end of the intellectual scale who share in the common designation of "retarded." This does not mean that there are uniform patterns of behavior for persons within a given IQ range, but the limitations imposed by the intellect do restrict methods of adaptation and offer a convenient design for considering behavioral characteristics.

The severely retarded

Parental concern with the behavior of their retarded children can best be considered in terms of how well the children are able to cope with the natural and social demands of the environment. The severely retarded (IQ's ranging below 35 in many classification systems; dependent functionally) are quite unable to cope with these demands through their own resources. As preschoolers they frequently need nursing care and have severe sensori-motor handicaps that interfere with the development of self care skills. Bowel and bladder training is difficult, not only because of the child's limited understanding but also because, in many instances, his nervous system has not sufficiently matured to permit voluntary control over these functions.

Even as he passes through school age and adolescence (chronologically speaking) the severely retarded child is still dependent on adults for most of his basic needs. By this time he may be able to walk and manipulate objects, but he is typically incapable of looking after himself. As an adult, he may learn a few words and be able to communicate his wants on the simplest level.

Comparing the developmental patterns of the severely retarded with those of normal children has little value. Although generally they follow the same basic sequence—sitting, crawling, walking, talking, etc.—considerable variations exist in the age at which these skills

are developed, if they are achieved at all. If other frames of reference are applied—psychological, social, sexual—the inappropriateness of the usual developmental criteria becomes even more apparent.

In some respects, the behavior of the severely retarded presents fewer problems than the behavior of the less handicapped. While their total and prolonged dependency is a strain on the family's physical energies and a drain on their financial resources, problems of care and behavior are fairly well confined to the orbit of family life, that is, when the individual is maintained in the home.

Few of the severely retarded ever develop beyond a mental age of 4 years. Some have such gross physical defects that they must be cared for physically as infants throughout life. Others are not limited to this low level of existence and exhibit some of the behavior patterns that characterize young children. They are often preoccupied with bodily needs, are sometimes negativistic and prone to temper outbursts, and are quite unable to delay gratification.

Behavior of this kind is realistically difficult to handle in the home. It is further complicated in some cases by destructive tendencies and masturbatory behavior and in nearly all instances by an unawareness of danger. All of this is a source of anxiety and embarrassment to parents and cannot be remedied as readily by the corrective measures and diversionary tactics that often succeed with less retarded persons.

With rare exceptions, the severely retarded are not a threat to the safety of others. They are seldom aggressive or assaultive, are usually sexually underdeveloped and lack reproductive capacities. Whatever management problems they present stem largely from their total dependency and need for constant protection and supervision.

The moderately retarded

In considering the behavioral characteristics of mentally retarded children and adults, it is well to note that whatever methods of subclassification are used—level of intelligence, degree of dependency, educational capacities—some arbitrary divisions between groups must be made. All measurements are in fact based on a continuum, so that individuals in the upper range of one category are hardly distinguishable from those at the lower level of the next category. For this reason some of the moderately retarded (IQ's from 35 to 50; semidependent functionally) demonstrate behavior patterns similar to those of some of the severely retarded, while others more closely approximate the mildly retarded. Furthermore the groups are not static in composition and some mentally retarded persons may move up or down categorically, depending on their life experiences.

With these reservations in mind, we might say that the

"average" moderately retarded, "trainable" or semidependent child reflects growth and behavioral characteristics that differ in some respects from the other retarded subgroups. Here, too, growth variations do not relate primarily to sequential development, but rather to how far development progresses and the role played by intelligence (as one of many variables) in this process.

Most moderately retarded children can be identified as retarded in infancy or early childhood. Usually the family physician, or the mother is first to recognize the lag in development. These children are slow in learning to walk, have poor motor coordination, minimal speech and little communication skills. As they grow older, however, especially if appropriate training is provided, they acquire language and communication abilities and are fairly capable in the areas of self-care. Though functional academic skills are generally beyond their capacities, some have sufficient manual abilities to perform useful tasks around the home and to contribute to their partial self-support through sheltered employment. With supervision and guidance, many are able to master the rudiments of daily living, to get along with others, to travel independently, to conform to society's rules, to use leisure time constructively.

"Trainable" persons evidence a wide range of behavior, sometimes organically induced, at other times functionally determined. This behavior is influenced by a blend of many factors—personality, interests, physical defects, motivation, likes, dislikes. Where there is severe brain damage, behavior is often excitable, unpredictable and uncontrollable. Frequently it takes the form of hyperactivity, aggressiveness and destructiveness. In these case, the individual has great difficulty in conforming to external controls and reacts against his frustrations in an extreme manner.

Not all of the "trainable" have "brain damage" in the physiological sense this term implies, and not all of the brain-damaged exhibit the behavior syndrome noted above. Many are highly tractable and responsive and can be taught acceptable conduct. Behavior, in other words, derives from many factors, some manipulative to some degree, others less so.

The existence of these variables, however, does not negate the importance of intelligence, or lack of it, in the determination of what mechanisms will be used in adapting to the environment. All persons, for example, are subject to frustration, anger and hurt. Most of us will handle these feelings by rationalization, by projecting blame toward others, by turning our hostility inwards, by self-controls of various kinds. However we defend ourselves and maintain our self-esteem, we are usually mindful of the needs of others and of how far we can go in these adaptive efforts.

To maintain this kind of ego balance requires a capacity for

reasoning and judgment that the moderately retarded generally lack. Like the young child, many of these persons are self-centered, tend to seek immediate satisfactions and have a low tolerance for frustration. When they are frustrated, they are more apt than normal persons to display violent tantrums or become immovably stubborn. Sometimes stubbornness stems from their lack of comprehension of what is expected of them, but often it is one of the few techniques they know for getting their own way.

The behavior of the moderately retarded adolescent and adult is childlike in many respects other than those already cited. Some are bedwetters, or thumb suckers; some masturbate often; some strive constantly for attention or are overdemonstratively affectionate. These traits are common, but they are neither universal nor inevitable. They can be corrected by applying some of the same techniques we use in modifying similar behavior in young children of normal intellect. (19, 20)

One of the most pressing, yet least well founded, of parental concerns is the fear that the moderately retarded adolescent or adult will engage in delinquent behavior or sexual misconduct. In actuality, the "trainable" seldom commit delinquent acts and when they do, rarely if ever is it deliberately and consciously planned. These individuals—in contrast to many of the mildly retarded—do not understand the nature of the delinquent act and its consequences. The damage they occasionally inflict on property or persons is more likely to be unintentional than willful. When more serious crimes are committed by these persons, such as stealing or housebreaking, it can usually be traced to the instigation and exploitation of more intelligent peers.

Parental anxiety regarding sexual misbehavior is also unrealistic in most instances. The moderately retarded young man is seldom sexually assaultive, the young girl infrequently an object of exploitation, though in both instances parents should be alert to danger symtoms and possible corrective measures. Many in this group never mature sexually and even when they do mature in the physical sense have little interest in the opposite sex or any concept of heterosexual relationships. Sometimes the attention-getting behavior, curiosity and gestures of affection used by young children, are misinterpreted as sexually motivated when engaged in by trainable youngsters and adults. These behavior patterns can frequently be overcome by guidance and training.

Some trainable persons, however, do show normal sexual development and desires. Coupled with poor judgment and controls, these individuals need close supervision for the protection of themselves and others. Sometimes this can be provided in the community; in other instances placement may be indicated. Whatever the level of

development, interest or desire, the fulfillment of sexual needs through marriage is totally unfeasible. The moderately retarded are wholly incapable of assuming the weighty responsibilities inherent in a marital relationship.

Current knowledge regarding trainable persons is largely the result of clinical impressions and direct observation, and is focused primarily on the problems and limitations they present. The developmental patterns and behavioral characteristics, which have been briefly described, are fair representations of how these persons generally function, without special help or training, in the usual situation. We have yet to isolate most of the many variables that determine *why* these persons function as they do, and only in very recent years has any real effort been made to explore and develop their potentials.

Undoubtedly there is much truth in the notion that trainables have difficulty in concentration, in appreciating cause and effect relationships, in adapting to extraordinary circumstances. It is also true that they cannot comprehend abstract functions and ideas (reading, writing, arithmetic), generalize from one situation to another, or describe familiar objects.

These limitations, while they preclude the acquisition of academic skills, do not obviate the values of occupational work and social training in the formation of other useful skills. On the basis of recent studies, it seems that some of these observed limitations can and should be modified (8 Chap. XIII). For example, given proper incentive and training, the trainable young adult *can* concentrate on a specific task and is capable of sustained and productive effort. Furthermore, not only is the speed and quality of his performance improved with practice, but there is some carry-over of skills from one task to related tasks. Often he is able to perform simple tasks as well as persons of greater intelligence, though it may take a longer period of training before he can do so. Most important, these studies indicate very little relationship between the initial ability of the moderately retarded and what he is able to achieve through training.

We have only begun to investigate the industrial capacities of trainable adults, but there is already much evidence that these have been underestimated. The social and vocational adjustment of these persons has been well documented in a recent study conducted in New York (21). In a follow-up survey of moderately retarded adults, educated in special classes between 1929–46, 38 percent (ages 17–40, IQ's in low 40's) were found to be working in regular jobs. Of this group, 3 out of 4 had been fairly steadily employed over a period of nine years. Earnings ranged between $5 and $60 per week. Only 7 percent had been "in trouble" with the law, despite the fact that the majority came from a low socioeconomic background. Most significant in cases of successful adjustment, was the extent to which the

parents accepted their retarded child. In families marked by high tension and conflict, three times as many of the retarded were institutionalized as in families characterized by warm, close-knit relationships.

These findings suggest a need to reexamine our traditional attitudes toward the moderately retarded. Though we cannot ignore the disabilities imposed upon them by biological and intellectual defect, neither can we overlook environmental factors and the possibilities of improved performance through training. In many instances, parents need not be resigned to a lifetime of unproductive idleness for their moderately retarded child. In the absence of severe physical handicaps, some can do useful and remunerative work under sheltered or semi-sheltered conditions and participate in some of the social and recreational activities of the community. Those who are given the help they need gain in self-confidence, show a greater tolerance for frustration, and evidence a much wider and more constructive interest in the world about them.

The mildly retarded

Of the three subcategories of mental retardation, the mildly retarded (IQ over 50; independent functionally), as we might anticipate, present the widest range of personality traits and behavioral characteristics. In contrast to the more severely handicapped, the behavior of most of this group is conditioned to a greater degree by psychological, social and cultural factors. Motivation, the individual's perception of himself and his outlook on life, his value system and capacity for cultural assimilation—all of these as well as his intellectual endowment influence the degree of his personality integration. Any description of fixed or stereotyped patterns of behavior would obviously not apply to the total group.

Generally speaking, the mildly retarded—regardless of etiology—have good potentials for social usefulness. As young children, particularly if they have no pathological defect, they are rarely distinguished from the normal population. The abilities which can be measured in the first few years of life relate largely to physical development and the DQ's (developmental quotients) of these children are usually within normal limits. Even before they reach school age, those in the upper range of mild retardation can develop social and communication skills and are quite independent in self care. The lower range group, especially those with organic involvement, may lag slightly behind in sensori-motor skills and personal-social relationships.

By the late teens, most of these children will have achieved their maximum educational attainment. For some, functional academic

skills at approximately the 4th grade level is the upper limit; others may progress as far as the 6th grade. Most of them can benefit from social-occupational training during and beyond school age and can be partially or totally self-maintaining as adults. Often they need supervision and guidance in situations of social or economic stress.

Within the mildly retarded or borderline range of mental functioning however, there is a sizable minority whose intellectual defect stems from comparatively minimal but demonstrable brain damage. In this group, as with other more extensively damaged persons, organicity plays an important role in behavior. But higher intellectual resources enable these individuals—with maturity—to better compensate for perceptual distortions and to exercise more adequate controls over their behavior.

The mildly retarded child who cannot exclude from his consciousness the countless stimuli which normal children usually ignore, finds his interest and attention diverted from the task at hand and his performance consequently affected. When this occurs, learning becomes difficult and classroom work a source of frustration and discontentment. Burdened by a sense of failure or anxiety and lacking in emotional controls, these children are particularly vulnerable to environmental stress and the development of conduct disorders. (For a fuller discussion of organic behavior disorders, see *Children,* 22.)

The behavior, thought processes and personality development of cultural or other non-organically retarded persons, parallels in many respects that of normal persons. Whatever differences exist are usually differences in degree rather than kind. The principles of learning, and the concepts used in the interpretation of normal behavior, have equal validity in the interpretation of behavior in the subnormal.

The young retarded child, for example, may not truly understand the meaning of failure and may react to situations involving competition and frustration as painful experiences to be avoided. He is more likely to learn acceptable behavior from positive experiences of an immediately satisfying nature. With greater maturity and understanding however, even the retarded child has some capacity for interpreting his experiences in terms of success or failure. When this level is reached, small failures may motivate the child to develop greater skills in handling frustrating situations rather than to just "give-up."

Appropriate responses to systems of reward and punishment and to success or failure develop at a slower rate among the retarded than among normal children. This factor needs to be considered in relation to curriculum content and classroom programming, for the retarded child spends a large part of his time in school. But this applies to other types of structured group experiences, and to the home

situation as well. Parents, educators, and others cannot impose the same pressures and performance standards on retarded children that they apply to normal children of the same age. Each retarded child should have his own intellectual yardstick and expectations should be raised as the child grows older. It is most vital for optimal personality development that parents provide tasks in which the retarded child can succeed and responsibilities he can reasonably carry.

In some homes, disappointment regarding the child's slowness in walking and talking prompts the parents to greater urging and heightens the child's sense of failure. Even where parental expectations are minimal, as is the case in some culturally backward families, competition in the school or in social activities with peers is often a source of failure.

The retarded child's inability to excel in intellectual and other pursuits tends to depress his level of aspiration. Whereas the adequacy of his initial performance may be determined by his limited capacities, his later performances and his approach to new tasks is affected at least in part by how hard he tries. Because of repeated failures, the retarded child is prone to avoid unfamiliar, challenging tasks or tends to anticipate his own poor performance and puts forth less effort. In either event a behavior pattern develops which lowers his efficiency even beyond what would normally be expected on the basis of his innate impairment.

Avoidance reactions, as a defense against frustration, are probably more persistent among the mildly retarded than among normal children, particularly as they grow older. Normal children frequently derive substitute satisfactions from some talent or skill by which they are able to compensate for failure in a specific area of function. Some have even been inspired by frustration to a more creative and vigorous attack on their problems. The mildly retarded are not altogether lacking in compensatory skills, though these are not always readily apparent and often must be consciously developed. When substitute satisfactions are not available to them, they are likely to regress to attitudes of defeatism.

Although avoidance behavior is a conspicuous characteristic of many of the mildly retarded, other modes of behavior should also be noted. Often, these children are confronted with so many barriers to success and so many demands for achievement, that these cannot be overcome by avoidance, except perhaps through withdrawal. To reduce the tensions that accumulate, the retarded child may react in various ways. He may respond with overt indifference or an external display of feeling; he may repress his hostility, turning his feelings inward; or he may "act out" his resentments. All of these responses and variations of them are utilized, but in the majority of instances, the "acting-out" mechanism is predominant. (23) In a minority of

cases, particularly where the individual has no constructive social outlets for his pent up aggressions, feelings may be acted out in a socially unacceptable though not necessarily delinquent manner. Should this occur, the attitudes of the community are apt to become even more uncompromising and hostile, thereby placing added stress on the individual's capacity for social adjustment. The interaction of these factors are partly responsible for the high incidence of emotional disturbance and behavior disorders among the mildly retarded.

A fairly widespread concern—shared by parents and public alike—is that the retarded are characteristically suggestible and "easily led" and that low intelligence is a primary cause of their social misconduct. Logic would suggest that individuals who are unable to discern whether what they are told to do is acceptable or not, are prone to get into trouble. And indeed this is sometimes the reasonable explanation for certain types of misconduct among the retarded. Where "gang" delinquency is involved, for example, the retarded are prone to be goaded into taking daring chances, thus becoming the "fall guys" for the rest of the group. In many instances however—particularly where these behavior patterns are well established—parental attempts to explain their retarded child's behavior as due to the influence of "bad company" are unfounded rationalizations.

Actually, not all of the mildly retarded are suggestible, nor are all persons of normal intellect free from this trait. The retarded as a group, nevertheless probably need more protection against exploitation than other persons. Their vulnerability is heightened at least in part by their unsatisfied emotional needs. The mildly retarded adolescent or adult is often "led into trouble"—even when he understands the unacceptable nature of his acts—because that may be the only way he knows to gain acceptance and recognition from his peers. Fulfilling these basic needs for "belonging" can minimize the suggestibility of some retardates and safeguard them from the negative influence of undesirable companions.

The exact role of low mentality in the caustation of delinquent or anti-social behavior is still unknown. Though a cause-effect relationship between deficiency and delinquency is being challenged by many of today's professional practitioners and researchers, the attitudes of the lay public toward this problem lag far behind current knowledge. This situation is clearly illustrated in recent newspaper articles prompted by public agitation over the high incidence of illegitimate children born to mothers on public welfare roles. In the views of one columnist: (24)

> The woman who continues to have children out of wedlock does so not because she is immoral or because she wants more money,

> but because in almost every instance she is a moron . . . Since morons tend to beget morons, . . . these subnormal women should be sterilized. Or, if that is too much for the squeamish to tolerate, they should be confined to institutions. They should not, in the interest of these children as well as society in general, be permitted to multiply their kind.

It is highly questionable whether the women who repeatedly bear children out of wedlock are in fact predominantly of low mentality and it is equally debatable whether the latter causes the former. These women usually live under conditions which may and do foster promiscuity and other forms of unacceptable behavior among them, whatever their level of intelligence.

Such ill-founded opinions and misconceptions as those expressed by the columnist are not to be dismissed lightly. They are partly responsible for the widespread fear of parents that their mildly retarded children will be exploited or become delinquent. Nor can the courts, welfare agencies, correctional facilities, institutions for the retarded, and other public supported programs fully escape the social pressures that such misinformation arouses. When these attitudes influence practice—as they frequently do—and the symptoms rather than the underlying causes of the behavior dictate the course of action to be taken, the problem is frequently compounded instead of resolved.

The exact incidence of delinquent behavior among the mildly retarded is not yet known. A summary of various studies, however, indicates that from 1934 to 1950, the percentage of defectives (IQ's below 70) in the delinquent population declined gradually from 13 percent to 4 percent. At the same time, the average intelligence of the total delinquent group rose from an IQ of 79 to 92 notwithstanding the fairly high proportion of disturbed adolescents whose test performance might be affected by emotional factors. (25) This marked differential does not necessarily reflect a true increase in the intelligence level of delinquents, though the higher incidence of delinquency among middle-class families may contribute in a minor way to this change. More likely, the wide variation in the results of different investigators is due to the use of varying criteria of defect, more refined testing instruments, greater awareness of other contributing variables and improved methodology.

The comparability of the intellectual levels of delinquents and non-delinquents (a difference of 8 IQ points) suggests little if any causal relationship between deficiency and delinquency, but this is not conclusive and more controlled studies are needed. Averages tend to conceal the extreme deviations from which the average is computed and the IQ, as stated earlier, is not a wholly reliable basis for estimating an individual's knowledge and ability to conform to socially

accepted standards of behavior. The impact of low intelligence on behavior takes on greater meaning when seen in relation to the host of psychological and social forces which contribute to delinquent behavior in *all* persons.

Considering that the mentally retarded—particularly the cultural-familial group—are often subject to adverse family and community conditions and are prone to "act out" their frustrations and hostility, it is surprising that the incidence of delinquent behavior among them is no greater than it is. An examination of their home environments reveals a significantly higher incidence of adverse factors than is found in the homes of brighter delinquents. (25, pp. 292–300) More family members have low intelligence, the educational, literacy and occupational status of parents is lower, home conditions are more frequently overcrowded and dirty, and the parent-child relationship is more often unfavorable.

The importance of these factors, and the equally obvious influence of negative social forces outside the home, preclude a single-factor view of causation. It cannot be stated with certainty how much measured intelligence is needed to distinguish "right from wrong" or to foresee the consequences of one's behavior, but there is ample evidence that most of the mildly retarded are not seriously handicapped in this regard. A recent study by Marden and Farber (26) suggests that retarded boys in institutions attribute status to their peers by the same value system that characterizes most of society. They respect cleanliness, conformity to rules and regulations, vocational and social independence, sociability and intelligence. Whether these values were learned in the institution or existed prior to admission does not reflect on the capacities of these boys to understand, and in many cases to incorporate, socially acceptable standards of behavior.

In personality traits, the mildly retarded who commit delinquent acts are more like delinquents of normal intelligence than they are like the retarded non-delinquent. They are prone to be impulsive, are lacking in self-control and demonstrate more hostility, resentment and defiance than the non-delinquent of average or retarded intellect. They are for the most part more assertive socially than most retarded individuals and express to a greater extent feelings of rejection and lack of status. (27)

The relationship of low intelligence to delinquency is aptly summarized by Woodward, in her survey of research: (25)

> **The conclusion derived from this survey is that low intelligence plays little or no part in delinquency. In a certain unknown proportion of delinquents, pressure to do work at a level or rate which is rendered impossible by low ability gives rise to stress.**

When there is a good deal of strain due to other adverse factors, this additional stress may exacerbate the situation and low intelligence may thus indirectly act as an aggravating factor, although it does not appear to do so in a sufficient number of cases to make dull children more numerous in a delinquent population than among comparable nondelinquents.

Parental fears that mildly retarded children will become delinquent would appear to be highly exaggerated. Lack of foresight and the incapacity to judge right from wrong are not *primary* factors in the delinquent behavior of most of these youngsters. The stress-producing effects of low intelligence are contributing factors, but these can, to some degree, be avoided. Given the opportunity for a favorable home environment, professional guidance and treatment, constructive social and recreational outlets, suitable work, and educational experiences among peers with whom they can compete on equal terms, delinquent patterns are not likely to develop.

chapter III

THE FAMILIES OF THE MENTALLY RETARDED

Family Related Problems

THE MULTI-DIMENSIONAL ASPECT of mental retardation has tended to obscure the fact that it is first and foremost a family problem. How efficiently the family can adapt to and handle the problem determines to a large extent how much responsibility society will need to assume in the care, management and treatment of the retarded individual. Only as parental functions are properly discharged can the retarded child make maximum use of community resources and realize a socially useful role for himself within and outside the home.

Retarded children are born to families in every strata of society—to the very poor and the very rich, the illiterate and the highly educated, the unskilled laborer and the scientist. Whatever the status of the family, whatever the basis or the severity of the child's handicap, the retarded child will have a significant and lasting effect on the lives of the other family members. Even the child who has no organic disorder and does not differ markedly from other members of the family makes his presence felt. Even when the effect on these families is not emotionally traumatic, the limited capacities of the child may engender conflicts with the schools and other social institutions or may be an inhibiting factor in the family's social operations.

In studying the needs of the families of the mentally retarded and in examining the problems with which they are faced, individualization is a paramount consideration. Families vary considerably in their reactions to the birth of a retarded child and in their ability to adapt their living patterns to the child's special needs. The early life experiences of the parents, their educational and cultural back-

grounds, their religious, social and ethnic values, their economic resources and the stability of the marital relationship, will influence their feelings and attitudes and their approach to the problems presented. The physical appearance of the child too, the severity of his mental handicap and the nature of his behavior will contribute significantly to the family's long range adjustment. And the attitudes of relatives, of neighbors and of the larger community may also play important roles.

The innumerable combinations in which these many variables may interact cautions against sweeping generalizations. Similar factors in the child's condition—for example, mild retardation—may produce dissimilar responses in professional families and in those less oriented toward intellectual achievement. Total dependency and special medical needs may be resolved by one family through placement in private residential care, whereas another may lack the financial resources needed for such placement. Facilities to relieve the daytime supervisory burdens of parents may be present in one community and lacking in another.

In general, the problems presented by retarded children as they relate to family life, are manifested in various ways: (1) family feelings and reactions, (2) care and management, (3) guidance and training, and (4) providing for the future. Which problems are predominant in a specific family depends on the factors noted above. For many, several effects bear down with equal impact on family stability and integrity.

Feelings and reactions

Many recent books and articles have focused upon the emotional impact of retarded children on their families. The few careful research investigations which have been undertaken—of which the study by Farber (28) is a good example—have been directed primarily to families of children who are severely impaired in intellect and behavior.

The selective nature of the subjects in such studies, while it in no way detracts from the value of the observations made, should make us cautious in applying these findings to children with lesser handicapping conditions. The reactions and adjustments noted are not representative of families in which the child's mental endowment approximates the other members, nor do they necessarily reflect what happens to families when resources to supplement parental care are available.

Considering for a moment the families in which the retarded child is truly "different," what does his birth mean to his parents and to his normal siblings?

The meaning of parenthood has great significance in our culture and the concepts parents have of themselves in this role are conditioned by our social values and our expectations for our children. For the large majority of married couples, the birth of a child is a happily anticipated event. Long before the pregnancy reaches termination, the unborn child is invested with many hopes and aspirations for the future. When he finally enters upon the scene, his achievements will provide much satisfaction; failures will evoke feelings of disappointment and personal inadequacy. For many parents, the child will be looked to as a source of vicarious satisfaction, the means through which they can realize goals unattainable by their own efforts or opportunities.

Our cultural emphasis on physical and intellectual prowess places parents of retarded children at a distinct disadvantage in facing up to many of life's routine experiences. The comparative development of infants, for example, is the primary topic of conversation between young mothers as they meet in the park, in the backyard or in social gatherings. At every important developmental milestone, the child is measured against his contemporaries. If he does not walk or talk as early as other children of his own age, if he is slow in being toilet trained or if he is less mature in his social behavior, uneasiness, anxiety or embarrassment ensues. Where the reasons for these developmental lags are not fully understood, parents may consciously or unconsciously punish their children for these comparative deficiencies. Many mothers do not feel free to love their children unconditionally when they do not measure up to established norms. But if they apply these social values and norms and reject their children, they are apt to be looked down upon by their neighbors and scolded by the "experts" for not loving their children enough. This conflict in our culture forces parents into devious and sometimes tortuous psychological escape mechanisms.

The child who is not in the "image" of his parents, and is grossly inferior to his peers, is a serious threat to parental self-esteem. Children are usually regarded by their parents as extensions of themselves: "If our child is imperfect, then we too must be imperfect in some way." Such thoughts are difficult to tolerate and when they are additionally complicated by overwhelming feelings of guilt at having created a defective child, a very common reaction is to deny that a handicap does indeed exist. (29)

Denial is a basic form of self-protection against painful realities. Some parents will turn their backs and close their minds to the child's limitations. They will rationalize it in terms of laziness or disinterest and dismiss the problem with the notion that the child could do anything he wanted to if he really tried. Symptoms of denial in parents are revealed in many ways. They are evident in

the parent's preoccupation with the one or two activities of the child that approximate normality when all other functions are markedly below par. They are evident in their inability to "hear" the diagnosis despite repeated interpretations, in the highly skeptical questions asked, in their "shopping around" from clinic to clinic. They are evident, too, in the tendency of some parents to stress the child's associated physical defects and to ignore his obvious mental limitations.

Reassurance that the child's handicap is not due to heredity (where this is the case), or to any acts of commission or omission by the parents, does not always help. Deep within many parents is the gnawing conviction that the child *is* their creation and that they are somehow responsible for his undeniable impairment. Where denial is completely irrational, as in certain cases of severely handicapped children, other defense mechanisms, such as projection, come into play.

For some parents, self-blame is too threatening to endure. They are prone to shift blame to the obstetrician for an incompetent instrument delivery or prematurely induced labor, to the pediatrician for improper treatment of the child's infection and fever, to the teacher for deficiencies in education and training. Nor are the parents themselves target-free. Particularly where the marital relationship prior to the retarded child's defect is already unstable, husband may blame wife, wife may blame husband and in-laws may also enter the fray.

Projections of this kind tend to create conflicts between parents and persons outside the home, and to heighten marital tensions. Although this defense mechanism may immobilize the parents from taking constructive action on behalf of their retarded child, in some respects it is a healthier adaptation than denial and more amenable to professional counseling than when blame and guilt are turned inward.

Few persons reach the stage of parenthood free of guilt-producing experiences. Every child engages in behavior at some time that merits his parent's disapproval and instills in him a sense of unworthiness. Sex behavior in particular, because of our cultural taboos and the need to repress both our thoughts and activities in this area, is an important source of guilt feelings. The possible relationship of these early experiences to guilt feelings in parents of retarded children, is graphically expressed by Dr. Spock: (30)

> And sex also happens to be the origin of babies. So the inevitable guilt left over from childhood—about touching the genitals, about sex play with others in early childhood, about petting in adolescence, about sexual thoughts in all stages of childhood—is stored up in a compartment of our conscience, all

> ready to beset us if there is anything wrong with our child. . . . As if this weren't enough, the conscientious obstetrician adds another link to the chain of potential guilt by prohibiting intercourse for such a long period before childbirth that a fairly large percentage of couples probably find themselves disobeying occasionally.

Feeling of guilt, and its corollaries of shame and possibly depression, are not readily verbalized and are sometimes difficult to elicit. The careful observer, however, will recognize these symptoms in the withdrawal of parents and child from social contacts, in their attitudes of extreme overprotectiveness, in the sense of punishment they express for things done or not done, in their pervasive mood of lethargy, sorrow, hopelessnes and immobility.

Other reactions during the initial adjustment phase are equally common. Hopelessness and frustration are evidenced in the urgency to place the child, in despair over problems of care and supervision, in inconsistent handling. Perhaps most prevalent and most pervasive is the feeling of fear—fear that the child will be unable to care for himself, will get into trouble or will have no one to look after him when the parents are dead or can no longer do so themselves. This fear is also reflected in concern regarding the effect on the normal children in the family and, not uncommonly, with respect to future pregnancies. (In a study by Holt (31), only one-fourth of the parents of mentally retarded children who were still of reproductive age and married wanted more pregnancies.)

Not all of the emotional feelings and defenses identified above are experienced by all parents, nor are they experienced with the same intensity or duration. For the most part, these reactions are not pathological in nature and in time most parents, with great effort, are able to reestablish a fairly normal family life. Much depends on their capacity to derive satisfaction from limited achievement goals, on their psychological and spiritual reserves and on the help they get from professional and community resources.

Other factors also influence parental feelings and reactions, some of them related to etiology or to the time of onset of symptoms. Of particular importance is whether the cause of the child's retardation stems from genetic factors or "environmental accidents." In the former instance, parents are confronted with the question of whether to risk future pregnancies or to consider adoption. Sometimes they tend to blame each other for the child's condition and their feelings of guilt may be projected years into the future, embracing the as yet unborn offspring of their normal children.

Similar fears are often expressed by parents even when the child's defect is due to injury, infection or other disturbances in fetal

growth. But the basis for the anxiety is somewhat different, and in the absence of complicating physical conditions in the mother, less real. In some genetically determined conditions, the probability of having a retarded child can be stated in mathematical terms. The "odds" are much greater for such parents than in most cases resulting from other causes.

The time of onset of the symptoms, before, during or after birth, must also be understood as an element affecting parental adjustment. Parents of children damaged later in life through injury or disease need not contend with the feelings of guilt or ego threat often associated with the "creation" of an imperfect child. They may, however, need considerable help in accepting the reality that their child will be less capable than before and in modifying their goals and expectations.

A primary, but perhaps exaggerated concern is the effect on other children. The widely held belief that retarded children should be placed away from home in the interests of the normal children is not borne out by experience. True, there are instances where older children are visibly damaged by the presence of a retarded sibling, but these are in the minority. In a study of 201 families of *severely* retarded children in Sheffield, England (32) only 15 percent of the families reported significant emotional disturbances among the normal children. Some of these children were extremely resentful of the attention given the retarded child, others developed attention-seeking devices, and still others withdrew from social contacts or attempted to compensate for feelings of emotional deprivation by applying their total energies to schoolwork. In only two cases was rejection by the family complete, and the normal children were reared and legally adopted by relatives.

Perhaps the most important finding regarding the reactions of siblings was that, in the majority of instances, the sense of shame and embarrassment felt was a reflection of the parents' attitudes and a measure of their adjustment. Also worthy of note—considering how often this argument is proposed as a basis for removing the child from the home—was the observation that only in one family was imitation of the retarded child by the normal child identified as a problem.

The study also supported the concept that community attitudes of aversion and non-acceptance still characterize public thought and contribute to parental attitudes toward their retarded child and to family maladjustment. In more than 60 percent of the families there was a significant degree of social isolation. Parents felt a sense of stigma in the stares and comments of neighbors, in complaints lodged against the child's behavior, in the unwillingness of other parents to allow their children to play with the retarded child. Only one-fourth of the families had helpful neighbors—more often in the higher social classes—and even these avoided direct contact with the retarded child.

The emotional hurt experienced by these parents was reflected in their social relationships and activities. Their circle of friends was generally quite small, probably because new friendships were looked upon as a potential source of painful and embarrassing questions. Their participation in civic and community affairs was low. These withdrawal patterns were observed in families from all social classes, even where neighbors were helpful and friendly and even in certain cases after the child had been admitted to an institution. The findings suggest that, in some instances, isolation is self-imposed and that if parents can be helped to reach out to the broader community, some of their problems can be lessened.

The observations and findings noted above, relative to the emotional reactions and social problems experienced by families of retarded children, graphically illustrate the tremendous impact of mentally handicapped children on family life. But it is by no means the total problem. Problems in care and management too—sometimes distinct from, yet often interrelated with feeling and attitudes —are often involved.

Care and management

Foremost among the problems of care and management presented by *severely* handicapped children are those deriving from their complete and prolonged dependency. Some require nursing care around the clock. They cannot walk, bathe, dress or feed themselves. Others less handicapped physically and mentally present behavior patterns which require constant surveillance not only during regular waking hours, but in some instances at night as well.

Extreme burdens such as these cannot be long endured without some form of help or relief. The health of the mothers—who usually bear the brunt of care for these children—can be drastically affected. They may suffer from chronic fatigue and nervous exhaustion, and occasionally may verge on mental breakdown.

Faced with these difficult reality problems, it is not surprising that older normal children are often pressed into service to share the burden of care and supervision. Older sisters, especially in lower social status families, sometimes become "second mothers." Often they have little opportunity to enjoy the usual pleasures and activities of childhood.

For some families, the care of retarded children is a severe financial drain. Extra costs are involved in seeking medical advice and treatment or in providing the child with training and recreational opportunities. Even board and lodging, from which the parents of normal children eventually obtain relief, may continue on indefinitely.

One of the most telling of the care and management effects of

retarded children upon families is the unwillingness of parents to leave them in the care of strangers or the reluctance of some individuals or agencies to serve in this capacity. Whatever the cause, the net effect is that the parents have little chance for relaxation and the temporary relief that may help them carry on more effectively. Under these circumstances, husband and wife seldom go out together socially or for holidays. The alternative of taking the retarded child with them is unappealing, made so by the strain of caring for the child in strange surroundings, by his antisocial behavior or by anticipated embarrassment.

Guidance and training

Many of the family problems noted thus far relate to the young retarded child or to the older child whose underdevelopment places him behavior-wise in the preschool age group. The kinds of problems experienced, however, are in a state of constant flux. As the child passes each developmental milestone, new crises may arise. When he enters school, he must adapt to a broader range of social relationships and face the competition of peers; later he and his parents must deal with the many fears, anxieties and problems which often attend puberty and adolescence; as an adult, the need for economic and social self-sufficiency are other obstacles the retarded person and his family must hurdle.

The years from 6 to 12 are even more crucial for the retarded child than for normal children. The normal child begins to act like the other boys he meets in school and play, in his manner of dress, personal grooming and language. He discusses with his school mates their notions of proper behavior, he forms secret clubs and in every way practices social organization and group living. Despite these beginning efforts at emancipation, children at this age still look to their parents for their basic security and moral guidance. But the influence of the school, the church, the Scouts and other social institutions become more and more important; social acceptance and responsibility *to the group* are fundamental values emphasized by the children.

Retarded children, on the other hand, often lack the social and emotional maturity at this chronological age to form group identifications. As noted earlier, opportunities for satisfying social relationships with age mates are often denied to them and where outside experiences are available, too frequently they are painful and frustrating rather than character building in nature. This places an even greater burden on their parents in the promotion of healthy personalities. The parent-child relationship, so vital during early childhood continues in its importance during the next developmental phase.

Parents are faced with the challenging task of helping their retarded children, largely within the home environment, though not exclusively so, to assume as much independence and responsibility as they are capable of. They also must be helped to develop skills in social relationships, emotional controls and proper behavior.

This task is frequently made more difficult by the retarded child's uneven rate of development in different areas of growth. Parents are puzzled when the child of ten has the physical build of other ten year olds, reasons like a five year old, behaves and relates to other children on a seven year level, yet often is quite lacking in self-control and resorts to the temper tantrums of a three year old.

This puzzlement changes to bewilderment and panic when the child becomes an adolescent. At this period, the need for peer relationships in social and recreational pursuits is even more acute. With nothing constructive to do outside the home, the problem of parental supervision is amplified and the retarded youngster is subject to boredom. When this is accompanied by a heightened interest in boy-girl activities, there is understandable concern for the child's protection. Parents wonder how much the child should be told about sex, if anything, and often tell him nothing—thereby sometimes contributing unwittingly to the problem. Often neighbors will express much uneasiness about the adolescent retarded boy, even when his overt behavior is above reproach. That these concerns stem from uninformed parental and social attitudes seems apparent but this makes the problem no less real.

Providing for the future

Family worries about the retarded child at home do not cease even when the family has successfully adapted its living patterns or the individual has achieved a reasonable degree of social usefulness. For those who must always have someone to look after their welfare and protect their interests, the future seems full of uncertainty. "Who shall care for my retarded child after I am gone or am too old to do so myself?"

Parents who have dedicated their lives to keeping their child at home are frequently reluctant to consider institutional placement as the ultimate plan. Knowing the difficulties that the management of a retarded adult may entail, the parents hesitate to impose this burden on their other children and fear to rely on strangers, whom they feel may lack the personal interest and understanding needed.

The prolonged life expectancy of many severely handicapped individuals strongly suggests that increasing numbers of parents will be faced with the anxiety-provoking prospect that their retarded child may survive them and will be dependent upon others for his continued

well-being. Even some of the less disabled cannot be expected to conduct many commonplace activities—negotiation of contracts, decisions relative to medical care, employment, marriage—with "ordinary prudence and judgment." These individuals need social and legal protection and personal guidance. Parental concerns with how to best safeguard their children against these future contingencies are yet to be successfully resolved in the vast majority of cases.

In some instances, the uncertainty of available resources for future care and protection has prompted parents to place their retarded child in institutional facilities long before the need was apparent, thus depriving the child of valuable growth-promoting experiences. Some are able to work out satisfactory arrangements with private institutions for lifetime care by establishing trust funds to cover support and other costs. Others have joined large scale group insurance programs, under the sponsorship of parent associations, as a means of providing for the child's future maintenance. Still others—unfortunately very few in number—recognize the need for a guardian of the person and make such designation by last will and testament.

Society, too, has an important stake in the welfare of retarded children and adults, not only in cases of parental death, but also in those families where the parents themselves are mentally incapable of adequately discharging their roles as "natural guardians." Where parents are unable to meet the physical, emotional or behavioral problems of their retarded child and cannot be helped to do so through professional services, society must assume this responsibility. One of the ways it can do this is by arrangements for guardianship. The need to examine existing practices in State guardianship programs and to consider more adequate safeguards for the mentally retarded has been reviewed in *Children.* (33)

The inadequate family

Mental retardation poses a different kind of problem to families in which the retarded individual does not deviate significantly from the family norms and standards. Whatever problems are encountered are largely attributable to the limitations of the parents in child-rearing and to the external pressures of the community, whose demands and expectations the entire family may fall short of. In these families, problems do not stem from the psychological trauma and ego threat occasioned by mental defect in the intellectually adequate family. Problems are more likely to be precipitated by the child's failure in school and parental resentment toward the school authorities, by conflicts with neighbors over the child's behavior, by the family's inadequacies in child care and supervision, by limited work skills and earning capacity.

The social pathology in these families, some of whom are members of the "hard-core, multi-problem" families so familiar to social agencies, arises from many causes. Retardation is only one of many factors contributing to the wide range of problems with which these families are beset. To the parents it may well be considered of secondary importance and, in truth, other factors are often more debilitating. Nevertheless, the mental handicap of the child is another link that chains the family to its very limited realization of life's opportunities.

Mental retardation, as a family problem then, is as diverse as the many causes which result in this condition and the differences in family and community situations which contribute to it. Each situation must be evaluated according to the factors—internal and external—that determine the form the problem will take and the dynamics underlying it. These complexities and their modes of interaction need to be better understood. Only as the focus of the problem is fully recognized and steps are taken to help families in its effective resolution, can the potentialities of the mentally retarded be fulfilled.

Factors in Family Adjustability

The problems which have just been identified are fairly representative of the effects which retarded children can and do have on the lives of other members in the family. It is important to note, however, that whereas these observations describe *what* actually occurs, further information is needed to explain *why* it occurs, and indeed why these effects *do not occur* in some families— at least not with the same intensity or disruptive impact.

The inclination of the helping professions to focus on pathology —whether patient or family oriented—is a natural one, for only as problems are manifested or anticipated, is help provided. But to fully understand the meaning of mental retardation in our culture and its potential impact on the individual, the family and the community, it is vital that we recognize the successes as well as failures in adjustment.

Those who have worked closely with parents of retarded children—within or outside of the professional relationship—can hardly fail to be impressed with the remarkable resiliency of the human personality. Many parents, despite the gravity of the problems confronting them, muster the inner reserve to cope with the situation and somehow manage to maintain the family's integrity. Although few normal parents can escape the initial trauma that comes with the

recognition that their child is defective, there is every reason to believe that in a large number of families, the child's condition is in time maturely acknowledged, accepted and handled. Witness the fact that of the total retarded population, only about 4 percent are in institutional care. Further breakdown reveals that only one in every hundred of the mildly retarded, one in every five of the moderately retarded and one in two of the severely retarded, are institutionalized. (34) Admittedly, there are thousands of retarded persons who need residential care for whom facilities are not available, but there are also many now in residence who are capable of community living. The point to be stressed is that the large majority of families are managing in some way to care for their retarded member in their own homes. Some are doing so at great sacrifice, others are adjusting marginally, and still others have suffered marked family disorganization. And in others—many more than we might expect—the presence of a retarded child in the family has not been detrimental but has instead contributed to a deeper sense of social and moral responsibility. Many have made a successful adjustment without benefit of professional services. Many more can do so if skilled help is provided when it is needed.

In view of these variations, we might well ask: "What are some of the more important factors that influence family adjustability to mental retardation?"

Socio-economic status

Of the many variables that determine a family's adjustment to retardation and the strategies it may employ in resolving its problems, the social and economic status of the family are among the most important. Although it would be quite invalid to assume that all families within a given stratum of society will react uniformly to the same basic problem, it would be equally invalid to assume that the factors associated with socio-economic status have no bearing on the outcome and that generalizations of a sociological nature do not apply.

Low income and low social status are highly correlated with many other indices of familial deprivation—broken homes, parental inadequacy, substandard housing, poor health and child neglect. The significance of these factors in family adjustment is well known to social agencies and has been skillfully documented in reference to mental retardation in a recent study of the problem in New York City. (35) This study and others clearly demonstrate that the large majority of the mentally retarded are members of lower class families. (36, 37) Social deprivation, as measured by these components, is a major factor in determining insitutionalization. Though resort to placement is only one criterion for assessing adjustability (in

some cases it may be the best solution), the true meaning of deprivation becomes apparent when comparisons are made between families whose children are institutionalized and those whose children remain in the home. The former are more frequently known to welfare agencies, to courts on charges of neglect, and are found living more frequently in substandard areas. (35, p. 11) Among the mildly retarded in institutions or in their own homes, differences in family pathology are not great; nearly all are deprived.

The family that must devote much of its energy and all of its financial resources to providing its members with the basic necessities of life may find the burden of a handicapped child beyond its capacities. The inability to provide diagnostic, training or therapeutic services or to purchase private residential care when public resources are not immediately available, may intensify the child's dependency, impede his development or deny the parents essential relief. Sometimes, even when community resources are available, the lower class family does not know about the specialized agencies that can help them with the particular problems of their retarded child. Often the family is not interested in obtaining help, or is catapulted into contact with the courts (because of behavioral difficulties) and precluded from using treatment resources. These factors—highly associated with low socio-economic status—may contribute to family disruption.

The pervasive and far-reaching effects of economic deprivation on the family's stability, relationships, motivations, behavior and living patterns are well documented and need not be reviewed here. These considerations suggest that services to the retarded child alone may not constitute a total solution. Only a general betterment of home conditions can have an appreciable effect on how well some of these families adjust to the problem.

In our society the adjustability of families to retarded children is also influenced by variations in social values, child-rearing practices, role expectations of parents and children and other considerations related to social status. Upper and middle class parents for example are characteristically career oriented, not only for themselves but for their children as well. Aspirations and expectations—for all members—are at a high level. Family goals are long range and well crystallized. Immediate gratifications are often deferred in favor of future objectives. Maintaining or raising the family's social status is assigned great importance and is an important consideration in decisions relating to work, education, housing, social relationships, civic activities.

Parents with these social values, who are able to keep their retarded child at home, are often compelled to make drastic readjustments in their living patterns or compromise with long held aspira-

tions. It is not uncommon for a father to refuse a promotion opportunity to another city because of a lack of resources for his retarded child, to move to another neighborhood because his child is not accepted, or to jeopardize the education of his normal child through the depletion of the family's finances on behalf of the retarded child. These patterns of adjustment reflect a certain degree of parental flexibility in modifying family goals and often enable the child to remain a part of the family unit, but they have obvious drawbacks. Conversely, many high status families will not, cannot or indeed should not, sacrifice the interests of the entire family for the retarded child. Their tolerance of deviance is low, their striving for status maintenance, high. In these cases, placement outside the home may reflect a high degree of family adjustability.

The willingness of many high status families to consider placement is influenced by the role assigned to family members as well as by the considerations mentioned above. In these families, child management tends to be more of a shared responsibility between husband and wife than is true of low status families. By virtue of the husband's greater involvement in this area of family life and his emphasis on the family's mental health and welfare, he is apt to be more sensitive to the possible injurious influence of the retarded child and more appreciative of his wife's burdens.

In contrast to all this, the low social status family expects less of its children, particularly in the area of intellectual achievement, is more accepting of deviation, and is more likely to direct its efforts toward immediate gratification of needs and wants. The presence of a retarded child does not interfere markedly with parental goals for the other children, although it may well affect the family in other ways, especially where the defect is severe.

The fathers in these families tend to see their role in a different perspective and in certain ethnic groups they are more likely to drift in and out of the family relationship than is the case among their higher status counterparts. They frequently are less involved in matters of child care and management and the difficult chore of looking after the retarded child usually falls mainly to the mother. Sometimes this is offset by the assignment of child care responsibilities to other children. But the father's relative detachment from the daily problems of management can lead to inconsistencies between the parents in their attitudes toward the child and in their adjustment to the situation. Children, too, are assigned different roles. Boys, especially in lower class families, are expected to be future "breadwinners." If the defect is too severe to permit the realization of this goal, the family is likely to be less tolerant than it would be of a similarly retarded girl.

Families differ too in some of the child-rearing methods they

use. (38) Lower class parents as a rule, more consistently employ corporal punishment and tend to rely less on reasoning or threats of loss of love in matters of discipline. In their orientation toward order and obedience, the child has some difficulty in developing internalized values and controls. Furthermore, the children of these families get little parental guidance in seeking entertainment or the solution to problems and are frequently impelled toward trial and error methods or are influenced by their equally inexperienced peers. Middle class parents, especially since the post-war period, are more permissive toward the child's expressed needs, but have higher expectations for the child, assign responsibilities to him at an early age and closely supervise him. The child is thus directed in the selection of his activities and helped to resolve his problems along lines of proven effectiveness and in accord with accepted cultural patterns and values.

These differences in child rearing have direct consequences for intellectual and personality development, but they also affect family adjustability, at least indirectly. The relative casualness of the parent-child relationship in lower class families, with respect to guidance and supervision, may be less conducive to the child's mental stimulation and not as well adapted to preparing him to cope with school demands and the expectations of middle class teachers. Then too, he may learn behavior patterns—especially if he is exposed to a slum culture—that make him more vulnerable to conflict with the community and create additional social stresses for the family. This is highly significant when we realize that behavioral difficulties within the home and community are a primary source of family maladjustment, leading to institutional placement.

Ethnic and cultural factors

Ethnic factors are not easily disassociated from cultural considerations and both are highly correlated with social status and income variables. For these reasons, the significance of these factors in a given family situation or among certain groups cannot always be readily determined, though the role they play in family adjustability is unquestioned.

Ethnicity—a term embracing nationality, cultural and religious entities and racial groups—has an important bearing on a family's values and aspirations and on its attitude toward disability, dependency or mental subnormality. In the "melting pot" of our society, minority ethnic groups tend to be assimilated into the larger culture, adopting its rules and regulations and, to a lesser degree, its values and customs. Yet even while this process is taking place and ethnic differences are becoming less distinct, these groups retain many "old world" traditions and pass on to succeeding generations certain char-

acteristic values or systems of social relationship.

Among ethnic groups of foreign origin—the French Catholics of the Northeast, the Spanish-Americans of the Southwest, Italians and Puerto Ricans in New York—language barriers may present adjustment problems for child and family alike. While it is not altogether clear that a child's mental development is either retarded or accelerated when the language spoken at home is different from what he learns at school, it is wholly possible that he may be mistakenly regarded as retarded if his school performance is under par or if he is socially maladjusted. Many standard intelligence tests rely heavily on verbal skills in assessing ability and it is often presumed that persons handicapped in language development will have difficulty learning the other aspects of culture essential to overall social functioning. Whereas most children tend to perform equally well on verbal and performance tests, this occurs with less regularity among certain types of retarded children and still less among bilingual children of foreign ethnic minorities. Several studies of these ethnic groups in institutional care indicate average performance on nonverbal tests, casting considerable doubt on the validity of their Binet IQ's as a single criterion in determining the appropriateness of their commitment. (39) (40) The Mexican children reported on in the study by Shotwell had Arthur scores averaging 22 points higher than their verbal IQ's, suggesting an excellent potential for community living. They and other ethnic minorities, such as the Puerto Ricans, constitute a larger proportion of institutional populations than might be expected from their incidence in the general population. In these committed cases, social and economic considerations undoubtedly compound the problem, but language development is a vital contributing factor.

The children of these families—in the absence of pathological defect—are usually minimally, if at all, retarded and are placed in institutions primarily because of behavioral conflicts outside the home. Frequently the family is resistive to placement and the child is unnecessarily stigmatized as mentally retarded. The child who views placement as punitive or inappropriate—as it may well be—may find substance for his hostility and continue in his obstreperous ways. His family too may react with resentment to the courts, the institution and other social organizations, thereby complicating their own adjustment and inhibiting constructive solutions to the problem.

Even where institutionalization does not take place, the bilingualism of ethnic minority group children may influence their personal and social adjustment. The child of limited mental ability, already vulnerable to failure and frustration, is subject to even greater social disapproval if he has not mastered the dominant language of his culture. He is confronted further by problems of identification with

the cultural values of his immigrant family and those of the larger society in which he lives. These culture conflicts are potential sources of family disharmony. While they are not peculiar to the mentally subnormal, they represent keenly felt stresses to family adjustment.

Language is only one aspect of ethnic-cultural variables which need to be understood in assessing the problems of mentally retarded children and their families. Ethnic groups also differ in other important respects—in their sense of responsibility toward children and each other, in their systems of kinship, in their concept of parent-child relationships.

Though very few studies have looked at family adjustability to mental retardation in the context of ethnic-cultural variables, there can be little question that these variables must be considered. The excellent analysis of Hutterite culture contained in *Mental Subnormality* (7, Chapter XV), though atypical, illustrates this most clearly.

> There is considerable social acceptance of mentally defective persons among the Hutterites. Once a child's retardation is recognized, he is usually taken to a doctor to determine if there is any medical remedy for the condition. If there is none, the child and his limitations are accepted fatalistically. The community provides the family with additional help, if needed, to give optimum physical care to the youngster. In some families the mother will turn the child over to a sister or her mother, who may have more time and patience. Feelings of rejection by the parents exist, but they are usually well repressed. Other children are punished if they ridicule or take advantage of the afflicted child. Defectives who reach adult life are encouraged to work.
>
> Defectives are not thought to be morally responsible for what they do. Those who engage in anti-social activities are punished only if they show sufficient insight to be affected by punishment. The community keeps them in line by watching them carefully. In two cases where mildly defective individuals violated a number of religious rules, the community "cancelled their baptism" rather than excommunicate them. By cancellation of their baptism they were reduced to the status of children, who are thought to be incapable of sinning and therefore can attain salvation automatically.

The ethnic values of this group are in marked contrast to the values of the community which surround their settlements and to other ethnic minorities as well. Yet in less obvious fashion and to a lesser degree, other ethnic groups show some of the same values, patterns of relationship and sense of protection for their less adequate or socially deviant members. These factors are part of the total configuration of variables which determine how a specific family views its

retarded child and the solutions it will employ in the adjustment process.

Religious factors

Religious convictions and beliefs frequently play a crucial role in parental reactions and adjustment to a retarded child. The impact is reflected in various ways, some good, some bad.

Some parents look upon their retarded child as a "cross they must bear" through life, a burden imposed upon them from a higher source. They may interpret this as punishment and retribution for past misdeeds—real or imagined—or they may regard the task of caring for the child as a divinely inspired opportunity for self growth and salvation. To these parents, religious beliefs may be either a source of guilt feelings or a spur to greater effort and achievement. In the former instance, intra-family relationships may be distorted; in the latter, spiritual satisfactions may promote family stability. Other parents grope constantly for answers to the eternal question, "why did this happen to me?" Sometimes they become so absorbed in this fruitless search, that they have little mental energy left to constructively carry out their day to day responsibilties. Still others approach their retarded child as a manifestation of God's will or think of him as a "Child of God"—pure in soul, undisturbed by the self-interests that motivate men of reason.

All of these reactions are commonly observed in counseling with parents. They suggest that religious convictions are not always utilized as a force for good and that many parents urgently need skilled guidance in this area by clergymen who are knowledgeable about the implications of retardation to families. For the most part however, the spiritual strengths derived from religious teachings have been a source of comfort and inspiration to families of retarded children and have contributed greatly to their successful adjustment.

Few attempts have been made thus far to investigate the relationship between specific religious doctrines, mental retardation and family adjustment. In the few instances where this has been done, some differences have been noted between the major religions—Protestant, Catholic, Jewish—with respect to the family's acceptance of the retarded child and their resort to institutionalization in public facilities.

Few, if any, studies have explored the intensity of religious feelings in the families reported upon, the participation of the parents in church-sponsored activities, or the extent to which they understood or reflected, in their behavior and thinking, the moral precepts of their religion. Until such investigations are undertaken, comparisons between religions as to their impact on family adjustment are at best

speculative. Nevertheless, there appears to be much substance to Zuk's comments that: Catholic doctrine provides considerable emotional support for mothers by its insistence that every child, normal or defective, is a special gift of God bestowed on the parents. Indeed, the birth of a retarded child may be perceived by the devout Catholic mother as a unique test of her religious faith." (41) The unquestioning acceptance of these precepts—which may apply to other religions too—tends to absolve the parents of strong guilt feelings and eliminates some of the major obstacles to acceptance of the child himself.

Religious affiliation can affect family adjustment in other, perhaps equally crucial ways. For some families, the church or synagogue is the focal point of social and community functions. These contacts provide not only opportunities for pastoral guidance and emotional support, but frequently place at the disposal of the family a host of sectarian-sponsored resources of which they might otherwise be unaware or fail to use.

It may well be that closeness to the church and adherence to its philosophy and moral teachings is a better guide to the influence of religious factors on family crises than the specific doctrine of any denomination. Whether this is true or not, the importance of religion as a factor in parental adjustment needs to be understood. Recognition of this fact by the professional worker may offer additional guides for therapeutic treatment and point the way to closer working relationships with the clergy.

Parental adequacy

Consideration of the sociological variables outlined heretofore, in no way negates the need for individualization. Neither should it obscure the fact that, in the final analysis, parental adequacy largely determines how well a family may adjust to a retarded child. Parental adequacy, however, does not rest solely upon internal considerations such as intelligence, maturity, emotional stability and other personality characteristics. The parent who is adjudged adequate by most standards of measurement, and who is indeed quite able to care for a normal child, is not necessarily equal to the task when the child is retarded. In evaluating the capacities of parents, it is important to consider the social, economic, ethnic, cultural and religious variables that shape their values, guide their behavior and help make them the kind of parents they are. These factors are operative in families with normal children too, but often assume special significance in relation to retarded children.

Since being a "good parent" involves not only love and understanding but also the provision of opportunities for optimal growth

and development, it is not surprising that the incidence of inadequate parenthood is greater among the socially deprived group. Whether these parents are rendered ineffective, or at least less effective, by the circumstances under which they live, or whether they are reduced to substandard living conditions by their own lack of talents, is a moot question. In either case, the correlation between family deprivation and parental inadequacy is high, though by no means perfect. Even the most disadvantaged families produce warm, loving, and capable parents.

The intelligence of parents has much to do with how well they can fulfill the child's needs, particularly as it bears upon their earning capacity, mental stimulation of the retarded child, care and management, and guidance and training. Yet, although the least intelligent parents are often the most inadequate, the most intelligent are not necessarily the best adjusted. Actually the latter, because of high expectations for their children, have great difficulty in overcoming their deep frustration and bitter disappointment. The more ideal parent—intellectually speaking—is the one who has sufficient intelligence and insight to appreciate the child's capacities and limitations and is able to accept lower achievement goals.

The stability of the marital relationship has obvious bearing on parental adequacy and family adjustment to retardation. Successful child rearing is generally a two-parent task and especially so when it is further complicated by retardation. Where homes are broken by divorce, death or separation, or where the marital relationship is physically intact but psychologically asunder, the burden of care is often too much for the remaining spouse. Quite frequently, these parents will look to institutional placement as a solution to their problems. In Saenger's study (35 p. 67) only four out of ten cases committed during the two year period preceding the study lived with both natural parents at the time of commitment.

The high incidence of broken homes among institutionalized children, cannot be attributed primarily to the effect of the retarded child on the family. True, there are some families where the mother's devotion to the child may cause her to neglect her husband and create a rift in the marital relationship that might otherwise not have developed. For the most part, however, where divorce or separation ensues, factors unrelated to the child's retardation are responsible. Unquestionably, retardation may aggravate an already precarious relationship and perhaps precipitate an eventual break; but where the marriage is solidly founded, its survival is likely.

The capacity of parents to adjust to a retarded child depends not only on their personal strengths and weaknesses, but on the impact of many environmental factors over which they may have limited control. On the other hand, adequacy—however it is defined—

is a relative quality and can be assessed only in relation to the problem to be resolved. In this connection, retardation in all its ramifications offers no true standard for measurement. Some problems presented by retarded children are a lesser threat to family stability than others. Many of these have already been considered in previous chapters, but one that deserves additional mention, in view of its influence on family adjustment, is the behavior of retarded children.

Behavior of retarded children

The growth and behavior characteristics of the mentally retarded, described in Chapter II, include a wide diversity of behavior patterns and suggest equally diverse effects on family adjustment. Much depends on the family's definition of acceptable behavior and on the specific set of values and expectations of the subculture of which the family is a part. We might expect, therefore, that certain types of behavior would be equally intolerable to all families, whereas other breaches of conduct would be more disturbing to some than to others.

Behavioral difficulties in the home and community—except possibly in the case of the severely retarded—are a major cause of institutionalization and thereby a fair index of family maladjustment. Categorically we could say that the child who gets along well with his parents and siblings has a much better chance to remain in the home than one who is unfriendly and hostile or gets into fights. This observation appears to hold true in most instances regardless of associated physical defects in the child or his level of intelligence, except so far as intelligence may be a factor in behavior.

The relationship of specific behavior to home adjustment is clearly represented in the following table from the Saenger study: (35, p. 56)

TABLE 12—Home problems reported by parents and/or agencies:

[Matched samples]

Difficulties at home:	*Percent of those in institution**	*Percent of those in community**
No problems	9	41
Problems	91	59
Depression or anxiety	20	6
Quiet, withdrawn	16	6
Clings, overdependent	23	20
Specific fears	19	11
Stubborn, disobedient	61	29
Restless, hyperactive	55	30
Temper tantrums, acts up	53	21
Violent, aggressive	35	9
Harms self, accidents	20	5
Destructive to property	26	6
Sexual problems	5	1

*Since a child may have more than one problem, percentages do not add up to 100.

It can be seen from these figures that certain forms of behavior do not markedly distinguish children in institutions from those in the community. This does not mean that "clinging, overdependent" behavior, for example, is equally well tolerated by all families. Higher social status families, we have noted, are characteristically more protective towards younger children, and tend to encourage this kind of reaction, sometimes unwittingly. They are therefore better attuned to endure it than the lower status family that expects the child to function with less parental attention and guidance. Stubbornness, agressiveness and acting-out behavior within the home, on the other hand, are better tolerated in Negro, Puerto Rican and other minority group families than in the middle class white family. Restless, hyperactive and destructive behavior are equally frustrating and disruptive to all families.

Variations among families are more marked when the normal or retarded child's social misconduct involves persons outside of the home or a violation of property rights. Illegitimate pregnancy, for instance, is a source of extreme shame and embarrassment to some ethnic groups. They will use all possible protective devices to keep the "family secret" or they may, conversely, treat the offender as a social outcast. Others accept such behavior more casually and do not reject either the wayward girl or her illegitimate child. Indeed, they may not even regard the girl as "wayward" and though their decision to keep her newborn child may be conditioned by a lack of placement resources, cultural values also play a part in their attitudes and in the decision-making process.

For the mildly retarded at least, sexual difficulties and other types of aberrant behavior, such as stealing, robbery, fighting, and truancy, are the major reasons for institutionalization. These patterns—especially sexual misconduct—occur with much greater frequency among those (35, page 59) committed to institutional care than among those who remain in the community. The act of commitment, however, is not a precise guide to the level of family tolerance. Where delinquent behavior of this sort involving retarded persons comes to agency or court attention, community interests tend to supercede family concerns. Though the family may prefer to keep its offending youngster at home, society—acting on the premise that the individual needs protection and cannot be relied upon to behave in a responsible manner—is apt to impose its authority in favor of placement. Then too, these families have fewer private resources by which to prevent the child's misconduct from coming to public attention than the upper and middle class groups.

We cannot assume that *all* families within a given social class, sharing the same religious convictions and economic advantages, will respond to the same basic problem with the same strategies. We can

assume, however, that the predominant characteristics and values of the group to which the family belongs do influence its attitudes and responses. For this reason, an understanding of these factors is indispensable to an understanding of the family situation and the formulation of an appropriate treatment plan.

chapter IV

CASEWORK FOR THE MENTALLY RETARDED

Casework With Parents

PARENTS OF MENTALLY RETARDED CHILDREN represent the total spectrum of human personality variation. Most are normal, average, well-adjusted people; some are maladjusted; others are neurotic, mentally incapacitated or intellectually inadequate. They differ greatly in their degree of usefulness to the community, in their own personal adjustment, in their capacity for parenthood and in their skill in handling life's many problems—including mental retardation.

While it is true that some parents of mentally retarded children—especially those affiliated with parents' organizations—share common interests and, to some degree, similar feelings and reactions, it would be fallacious to assume their homogeneity according to any criteria by which persons are assessed. Each set of parents is uniquely different. Casework goals and the techniques used to achieve these goals must be related to their total psychological functioning as people, not just as parents or as parents of retarded children. Whatever their differences, most need and can profit from professional casework services.

There is a regrettable tendency in much of today's literature to categorize all parents of retarded children as guilt-ridden, anxious, insecure and emotionally traumatized persons. That these symptoms are frequently observed is undeniable, but it is important to emphasize the fact that these reactions are not universal nor are they experienced with the same intensity or duration. To the extent that parental reactions are presumed or pre-judged, we run the risk of approaching each casework situation in a stereotyped manner and misdirecting treatment efforts.

The previously well-adjusted parent is generally capable of enduring the emotional hurt and anxiety of a retarded child without severe personality disorganization and readjustment. He may experience temporary situational maladjustment and need some therapeutic reassurance and support, but his primary requirements are often largely educational in nature—understanding of the child's potential, guidance in care and management, referral to appropriate resources and services. In working with parents who have not achieved a satisfactory adjustment prior to the birth of the retarded child, casework treatment of a therapeutic nature may need to be aimed *ultimately* at the parent's personal and marital conflicts rather than their feelings relative to the retarded child. Failure to diagnose the true basis for parental maladjustment may result in support of an existing neurotic pattern and help neither parent nor child. Work with culturally deprived parents involves still another set of dynamics. Here the focus of activity may be directed primarily toward a betterment of home conditions, advice and guidance in child-rearing and homemaking, and motivating the parents toward self-improvement.

Casework treatment has three major objectives: (1) to obtain information pertinent to diagnosis and treatment, (2) to prevent or eliminate conditions and attitudes that contribute to social dysfunction, and (3) to enable the parents to make maximum use of their own and community resources toward a solution of the problems with which they are confronted. The processes by which these objectives are realized are not discrete and include both educational and therapeutic components. They are part and parcel of the single continuum of study, diagnosis and treatment.

In any highly charged emotional situation—so characteristic of the earlier phases of adjustment to mental retardation in many families—the giving of information by the parents has both anxiety-provoking and therapeutic effects. Similarly, in the treatment process or in the interpretation of diagnostic findings, the responses of parents and their ability to use the interview constructively offer additional insights into their strengths and weaknesses.

Social diagnosis

Casework with parents may be initiated by the parents themselves or upon referral from another source. Whatever the basis or motivation for agency referral, the diagnostic process—if it is to serve as the foundation for a treatment plan—must embrace not only the many factors relevant to the child's condition and level of functioning, but also factors regarding the family and community as well. The complexity of the information to be obtained, analyzed, interpreted and used, calls for the contributions of many disciplines in *some* cases

and at least a core group of the doctor, psychologist and social worker in *all cases.* The specific contributions of the major professions have been thoughtfully set forth in recent literature. (42)

Realistically, these appropriate professional services are not available in all social agency settings, but these limitations can be minimized to some extent by effective collaboration with other agency resources and private practitioners. Unfortunately, in many settings, even where interdisciplinary services are available, they are not always used. Courts responsible for commitment to institutions often rely on medical evaluation alone and are often oriented more toward the determination of deficiency than the assessment of the individual's need for placement. In public schools and welfare agencies, except where a gross defect is apparent, medical resources are not always utilized and too much reliance is placed on psychometric examination. Perhaps only in highly specialized clinics, treatment or rehabilitation centers, and in some institutions, are the major disciplines invoked in an intimate working relationship in the diagnostic process.

Our growing understanding of sociological and psychological phenomena in mental retardation, and of the familial and environmental forces which affect intellectual and social performance, highlights the importance of the social worker's role in diagnosis. The potential scope of the worker's exploration has already been outlined in previous chapters. It must nearly always include an evaluation of intrafamily relationships, parental strengths and weaknesses, the needs of parents and siblings as individuals, attitudes toward the retarded child and the resources of the family to meet the child's needs. Frequently, a full understanding of these diagnositc components rests upon the worker's appreciation of religious, ethnic and cultural variables. The meaningfulness of this information for diagnosis and planning depends on factors related to the child as a person—age, degree of handicap, behavior, personality, sphere of activities—and on the kind of problems and service needs presented. In some cases, certain areas of information have little bearing on the problem and their investigation would be regarded as an invasion of privacy. In other cases, the same information could be crucial in arriving at a total understanding of the situation.

Wherever possible the process of case study should be unhurried and therapeutically focused. Parents who are just beginning to be assailed with doubts about their child's normalcy—a situation first manifested in some children at school age—are in a highly vulnerable emotional state. Often they are confused and bewildered and their sense of self-confidence and adequacy are threatened. Recall of past incidents is often hazy or inaccurate. Certain events are exaggerated or vested with more significance than warranted. Under these circumstances, the information provided may not be totally

reliable, and the act of sharing such emotionally laden information may stimulate intolerable feelings of self-recrimination and doubt which some parents are prone to suppress. Or the converse may be true, and the compulsive unburdening of the parents is so complete that they feel naked and exposed at having disclosed so many of their inner thoughts and torment.

In many of these instances, the substance of the story told by parents may have less diagnostic import for future planning than the emotion with which the story is related. If the handling of these emotions by the professional worker is to have positive effects and lay a groundwork for later constructive action by the parents, it is important that the parents have the opportunity to ventilate their anxieties and fears. Here the worker must strive for a delicate balance. He must learn enough to understand the problem but should be careful to avoid a premature exploration or complete revelation of feelings that may shatter the parent's defenses. This objective may be achieved by the same basic casework techniques that govern similar situations with other disturbed or anxious clients—empathy and support, redirection of the discussion to less threatening areas, reassurance and acceptance. It is also very helpful to verbalize for the parents some of their concerns and to help them see that most parents in similar circumstances feel as they do. Proper timing—a keen sensitivity to parental readiness to share inner feelings and concerns—is of the essence. As the worker-parent relationship becomes better established and mutual trust and respect is developed, disturbing feelings can be discussed with greater security.

Elements in casework

Because the initial phase of adjustment is perhaps the most crucial, the questionnaire approach or interview, rigidly structured around causation, behavior, management or other child-focused considerations is not always fruitful. This technique does not readily lend itself to effective communication—though it does not necessarily preclude it. Often, when this approach is used parents who have little chance to express related anxieties are apt to regard the caseworker as unfeeling and uninterested in them as individuals. Lacking rapport, they will be reluctant to confide their personal concerns and conflicts and will tend to "tune out" interpretation of their child's limitations. They react with resentment to such treatment and if the caseworker should recommend their child's immediate institutionalization—a frequent occurrence, unfortunately—they will regard him as unsympathetic and abrupt. These are some of the reasons underlying parental dissatisfaction with diagnostic interpretations and discontent with professional services. Even when they have a

good intellectual grasp of the situation, emotional acceptance may be lacking because they have not had the opportunity to release pent up feelings or to participate fully in the evaluation and planning process.

Professional honesty with parents is essential, for evasions are readily sensed and false reassurances only heighten the ultimate sense of disillusionment. Honesty, however, need not be accompanied by brusqueness or an impatience with parental disbelief. When the social worker displays these attitudes, it often reflects insecurity in handling painful interpretations or a feeling of impotence that nothing can be done to improve the child's condition or to remedy the problem.

The above comments are not representative of the initial casework needs of all parents of retarded children. Much depends on how long they have lived with the problem and how well they have adjusted to it, their previous experiences in seeking help and whether they are motivated to use help or it is being forced upon them. Parents seek or are referred to agencies for help for a variety of reasons. Some are looking for authoritative confirmation of their own suspicions regarding their child's slow development. Some want help with problems of behavior, training or placement and have fully accepted their child's retardation. And some are confronted with the problem of retardation for the first time when the child's failure in school is reported, or when he is brought to public attention through the pathways of neglect, dependency or delinquency.

The dynamics in each of these situations, though similar in some respects, have obvious differences as well, and these influence the focus of the casework relationship, not only in the initial period but also in later interviews. These differences are most marked between families whose child does not measure up to their expectations and those in which the child's deficiency is not recognized or he functions on a level comparable to other members of the family. In the former, particularly if conflicts have not yet been resolved, therapeutic considerations are predominant. However, where the parents are emotionally well adjusted to the situation, emphasis on the educational components of the casework process may be more meaningful. For them, answers must be found for such questions as: "How can I teach my child to be toilet-trained, to feed and dress himself? How can I control his temper outbursts and aggressive behavior? Where can I get for him the education, training, recreation and social companionship he needs? What patterns of development can I expect and what will my child's potentials be?"

The answers to these questions are of practical importance in enabling parents to handle daily problems and project future plans. But although the focus of some interviews may be primarily educational, knowledge in itself often has therapeutic benefits. To the

extent that anxieties may be minimized, uncertainties dispelled and fears removed by the sharing of factual information, parental security may be enhanced. The secure parent is better equipped to provide a healthy climate in which the retarded child may flourish.

With many retarded children, the problems encountered in promoting independence in self care do not result from inadequate techniques in training, but from the growth-inhibiting attitudes and feelings of the parents. Unless the child has a severe physical defect which does not permit him to perform certain functions, or is so limited mentally that he can neither be conditioned to nor taught a prescribed mode of behavior, he can usually learn self-care skills. Considerable repetition is frequently needed and more complicated processes need to be broken down into simple, successive steps, but the method of teaching is basically the same as would be used with normal children.

When retarded children fail to develop these skills even after allowances are made for developmental lags, the problem can often be traced to impatience, frustration, overprotection, or inconsistent handling by the parents. These attitudes and responses stem from many sources. In some cases they reflect the parents' characteristic way of handling the task of child-rearing even for their normal children. Sometimes parents take the "easy way" out; it is simpler to do for the child than to take the time to teach him. In other situations, however, the child's deficiency has activated feelings of anxiety, guilt and sometimes aversion, which color the parent-child relationship. Most retarded children usually sense how the parent feels and react accordingly. The child whose aggressive acts or temper outbursts are either rationalized or countenanced soon learns to manipulate his human environment. In many instances—despite limited intelligence—he is shrewd enough to get his own way without the compromise and conformity essential for social development.

To provide a setting conducive to learning the elements of social living, it is important that these feelings be resolved as soon as possible. If they are not too deep seated, they can often be approached by a concentration on the concrete problems of training, management and discipline. The key to greater independence in the retarded child is patience and understanding in the parents. Sometimes this can be developed through an interpretation of the child's readiness to assume certain tasks and by demonstration of effective teaching techniques. Frequently parents need to be helped with their feelings of disappointment in the child or with problems of marital dissension before they can readjust their goals and apply child-rearing methods with telling results.

Many parents—once they are freed of inhibiting emotional factors—can be guided in the choice of play equipment and activities

that will improve the child's sensori-motor coordination or better suit his level of development and thereby eliminate for him potential sources of failure and frustration. Young retarded children are apt to be disinterested in certain kinds of educational toys that call for skills in assembly or spatial perception. They are likely to get more enjoyment and stimulation from toys or household objects they can push, pull or throw or make noise with.

Other parents need guidance in identifying the kinds of household chores their retarded child can and should be given responsibility for. They must be helped to understand that it is not only proper to impose responsibilities upon the child but imperative that they do so in accord with his capacities to assume them. As the child experiences success in the handling of objects and in the performance of simple tasks, his ability to concentrate on other tasks is enhanced and his emotional controls are strengthened. With these gains—sometimes quite dramatic in nature—parents tend to regard the child's future with optimism. Equally important, as the child learns to do more for himself, the parents' burden of care and supervision is somewhat relieved and greater patience and tolerance on their part becomes possible.

Another objective of working with these parents is to counteract their social isolation and withdrawal tendencies—frequently self-imposed. Although some people are unthinking in their comments and unwilling to permit their normal children to play with a retarded child, generally their basic attitudes toward the parents of retarded children are sympathetic and understanding. Unfortunately, however, these parents sometimes interpret the actions of their neighbors as rejection of themselves and rather than risk these emotional hurts confine their social activities to the family circle. Constructive social outlets are vital safety-valves; their lack intensifies tensions within the home and is disruptive to family stability.

The social worker's acceptance and understanding of the parents as persons with their own needs and rights can relieve the bitterness and distrust they sometimes display. But the worker-client relationship is not an island unto itself and there may be little carry-over of positive feelings toward others if the retarded child and his parents are continually buffeted by rejecting community attitudes. In these instances, parents may be encouraged to interpret the child's behavior and condition to their neighbors and thus reduce unfounded fears and suspicions. Where the attitude of a particularly troublesome neighbor cannot be handled in this fashion, the worker may well weigh the advisability of making an interpretation to the neighbor himself.

Even where parents gain acceptance for themselves, the retarded child—especially if his handicap is severe—may have little oppor-

tunity for social companionship or may be unable to participate in the social activities of his peer group. Parental attempts to foster relationships with other children through sponsoring parties and special outings frequently do not result in enduring associations. The worker can be very helpful in this regard by bringing retarded children and their parents in contact with each other in small informal social groups as well as through membership in organized parent groups.

Parents are usually the major focus of treatment and the goal of this treatment is to enable them to use their personal resources more adequately to cope with the problem. But other members of the family may also need to be accepted as direct clients in the casework process. This applies primarily to older normal children, but may also include other significant relatives, especially if they are members of the parents' household. The relationships of each member of the family to each other and to the retarded child is nearly always influenced in some meaningful way by the latter's presence.

Disturbances in the siblings of retarded children generally coincide with disturbances in their parents. Ordinarily, changes in parental attitudes will relieve conflicts in these children, but there are some disturbances stemming from sources outside the home which the parents cannot handle. The normal siblings of a retarded child cannot always escape the unkind words or unwanted pity of peers or adults. Nor can they easily disregard a sense of disappointment when friends boast of the achievements of brothers and sisters, or their feeling of embarrassment at large and important family affairs.

To combat these forces, the older sibling should be recognized as an essential element in family adjustment and should be included in the study, interpretation and treatment phases of the casework process, as appropriate. Ofttimes, parents cannot bring themselves to share the painful knowledge of their child's deficiency with their other children, and later interpretation can be made by the worker on an individual basis or to the family as a unit. The method of choice will depend on the personalities of the people involved and the age of the normal sibling. But the latter approach—family counseling—has the real advantage of facilitating communication between the parents and their normal children and allowing each, in the presence of the others, to raise questions of interest and concern. (This relatively new technique has not yet been applied on any scale to families with retarded children, but may have real value in implementing "family-centered" treatment.) The early involvement of siblings can do more than promote their understanding and acceptance. It can help define their relationship to the retarded child and instill in them the conviction that they are important contributors to his welfare and to the well being of the family. The parents may be helped too,

in the knowledge that their burden is shared and in the strength derived from family unity and free communication among its members.

This approach may prevent emotional disturbances in some siblings, but it does not preclude the need for constant reassessment of family dynamics and the worker's alertness to symptoms of conflict and anxiety in the normal child. Where such symptoms are persistent and severe, work through the parents or with the family as a unit, may not suffice. The sibling as a primary client for casework or other professional services would then need to be considered.

The limited parent

The problems posed in working with parents who are themselves inadequate or mentally retarded usually center around factors other than the child's retardation, unless the child is severely handicapped. Frequently these parents come to agency attention because of the community's concern with the child's antisocial behavior, his school maladjustment, or substandard conditions in the home. Many of these families are particularly difficult to reach because of their social isolation. They seldom participate in the usual civic group activities, have few friends, and are therefore somewhat outside the influence of their neighbors. For these reasons, they have little concern regarding the community's attitudes toward them, their desire for social approval is low, and little initiative is exerted to improve their child-rearing practices or poor living conditions.

The objective of the casework relationship in services to these parents is to strengthen their capacities by guiding them in the more effective discharge of their responsibilities and by motivating them toward self-improvement. This task is one of the most complex confronting social workers and it is further complicated by the authoritarian role in which the worker is usually placed—a role to which such families often react with resentment and hostility. While there is much to be learned in this area, there is little question that some of our difficulties in working with these parents stem from our own need to be authoritative rather than the use of our authority judiciously in response to the parents' need. Also, we sometimes judge the behavior of these individuals by our own middle class standards and values. We disqualify them (in our own minds) as parents because of their mental aberrations or limitations. Too often, we do not give them sufficient opportunity to demonstrate what they may be able to do with skilled professional guidance.

It is true that *some* of these parents lack the capacity to regulate their own behavior or that of their children. The worker ***in these instances*** may need to apply his authority in the form of judgments as

to right or wrong to protect these parents from choices that are inimical to their best interests. With proper advice and guidance some of these parents can be helped to function more adequately in the immediate situation and gain sufficient insight and confidence from successful experiences to apply these skills in future situations.

These parents usually come to social agency attention with a background of failure, or at best marginal success, as wage earners, marriage partners, or citizens. These life experiences are frequently associated with disability for parenthood as well. To confront the parent with further evidence of his inadequacy or to advise him of his child's deficiency—a totally incomprehensible observation for some—is ego-damaging. Some will react with hostility and denial and regard the worker as another source of community persecution. Others may be so psychologically "beaten", that they respond with apathy or docility and have neither motivation nor drive to improve their situation.

If the limited parent is to be helped to discharge his responsibilities more effectively, he must be safeguarded as far as possible from further attack on an already weak ego structure. Though the worker cannot ignore the presenting problem or the complaint that may have initiated the referral, he can convey by attitude and manner that the parent is interested in his child's welfare and is probably in the best position to do something about it. Only as the worker truly respects the integrity of these parents—however substandard they may be in measuring up to social norms—and stresses their abilities rather than disabilities, can progress be anticipated. The worker who is accepting and sincere presents a quite different picture to these parents than they probably expected. Freed of suspicion and distrust, the limited parent can make better use of his resources.

In working with retarded parents accused of neglect, it is wise to keep in mind that such neglect may not be willful in nature but the result of ignorance or of burdens that exceed their limited capacities. The tasks of household management, of providing nutritious meals, adequate shelter and clothing and proper child care and supervision, are a challengce to any family. When these tasks are further complicated by low income and a large family, they can overwhelm the parent who is unresourceful, immature and lacking in judgment. Sometimes a retarded mother who is devoted to her child appears to be neglectful, because her total energies are consumed with the practical problems of home management and her husband shares in few of the responsibilities.

Many of these mothers want to be better parents but become apathetic about it in the face of repeated frustrations and community threats; their true need is for community support. Casework in these instances often needs to be focused on providing concrete services. It

is not enough and probably undesirable to tell these mothers what they are doing wrong or what they have failed to do (at least early in the relationship). They need practical advice and guidance in the arts of homemaking and child care, budgeting, and the judicious use of their time. They—and their husbands too—need encouragement to broaden their sphere of activities and relationships. Above all, they need recognition for their achievements and a sense of self esteem. To the extent these objectives are achieved, these parents begin to care what their neighbors think and strive for self-improvement. Furthermore, they have been provided the practical tools to ward off hostile community pressures and to bring themselves more in line with society's values and standards. Not infrequently, the mother's heightened homemaking skills reduce conflicts with her husband and contribute to a more wholesome family atmosphere.

The social worker-client relationship is particularly well suited to promoting feelings of self-confidence and developing self-help skills. Some workers, however, may not have sufficient technical knowledge of the practical arts to offer guidance in these areas and will need to call upon the homemaker, home economist or other specialist for the complete fulfillment of casework goals.

Casework as a process of social diagnosis and treatment, then, is as diverse as the parents who need this service are different. The objectives in each case must be carefully assessed on the basis of the presenting problem, the parents' own needs and attitudes, and their capacity to profit from this service. In many instances casework is an indispensable component in work with the mentally retarded. Frequently it must be supplemented by concrete aids in health, training, recreation and other welfare services. Seldom—where problems of social and emotional disturbance exist—can significant solutions be achieved without it.

Casework With the Child

The application of new knowledge in mental retardation through the use of the casework process with the retarded client has been slow to develop. Whereas many agencies utilize casework and even group work methods with the *parents* of the retarded, there is a widespread belief that casework techniques cannot be effective with the retarded themselves. In support of this position, it has been argued by some authorities on psychotherapy—a treatment technique with great influence on social work practice and methodology—that the retarded individual (1) has little awareness of the interpersonal nature of his problems, (2) does not seek help of his own accord, and (3)

cannot understand the purposes, responsibility, or the role of the individual offering help.

In truth, some of the mentally retarded, whatever the degree of handicap, present personality and behavioral traits that might preclude the development of a meaningful relationship with a caseworker or therapist and thereby limit the potential for problem-solving activity. Some may be lacking in emotional controls, have a low tolerance for frustration, or lack the judgment or opportunity to find suitable and constructive outlets for their unfulfilled needs. Some may have little insight into the causes or consequences of their behavior or show no willingness to consider the needs of others.

But these attributes do not characterize all of the retarded, nor are they obviously confined to persons of low mentality. What is common to the retarded, albeit in differing degrees, is their impairment in judgment and verbal communication. Considering that language is the primary means of communication between the caseworker and client, it has been assumed that ordinary interviewing techniques are inappropriate. Theoretically, the retarded client is presumed not to know "his problem" because he cannot verbalize it to himself or to others and to be so lacking in insight and comprehension that he is unable to see his problem in relation to the behavior and standards of other people. Thus, the lack of verbal communication allegedly deprives him of the guidance he needs to resolve his difficulties.

These theoretical suppositions have not been sufficiently tested in practice to warrant their acceptance as a guide to casework practice. On the contrary, there is a growing body of knowledge derived from expanding social service programs and reported in the literature that supports the feasibility of casework techniques with the retarded. (43) The opposing points of view seem to depend in large measure on whether or not the therapist-authority has had extensive experience with retarded clients; those who have had such experience, for the most part, are strongly convinced of its value. These professionals feel that the casework process is an appropriate tool in promoting the personal and social adjustment of the retarded client, and is an indispensable element for those experiencing situations of social or emotional stress. It cannot be applied to all segments of the retarded population, but it can be used with beneficial results for those of milder retardation and even some with more severe disabilities. Intelligence is not the sole determinant of a retarded person's capacity to profit from a casework relationship, but it is highly correlated with verbal skills and its importance cannot be ignored. The greater the individual's deviation from normal intelligence, the greater the need to rely on nonverbal communication skills, and the greater the responsibility of the worker for direct advice and guidance. Other modifications of techniques, stemming from the retarded individual's

dependency and immaturity, are frequently necessary, especially in the area of environmental manipulation. While such considerations are not unique to the retarded and apply in individual situations to others who for various reasons—age, ineptness, severe emotional disability—lack the capacity to act wisely in their own behalf, they can be more commonly applied to this group of individuals than to other diagnostic or problem categories.

Adapting techniques

Social casework is defined as "a process used by certain human welfare agencies to help individuals to cope more effectively with their problems in social functioning." (44) This goal is achieved through (1) a therapeutic relationship of worker and client that supports the client and enables him to understand his problem and its possible solutions and (2) opportunities or resources that ameliorate the stress situation or permit the client to use his personal resources toward more effective functioning.

The mildly retarded adolescent or young adult is particularly liable to the development of problems in his social behavior and relationships. Frequently he is exposed to damaging home conditions, his behavior violates the community standards and he learns to resent or distrust persons in authority. Unhappily, in many of these instances, even when the retarded individual can assess his problem, the tangible social, recreational and employment resources needed by him for recognition, status, and a sense of acceptance are not available.

Many of the retarded are unable to solve their problems because they do not understand them or have not developed skills in handling them. The mentally limited mother who is overwhelmed by the burdens of a large family and homemaking duties is one example. The adolescent girl who is denied companionship with boys because of parental fears and anxieties is another. Some of these mothers can be taught in the casework relationship what they did not know and provided, through training, with skills they did not possess. Similarly, interpretation can help the parents understand their adolescents' need for social relations, and guidance can help the adolescent to conduct herself appropriately.

For many of the mildly retarded who come to agency attention the problem is one of deep personality maladjustment of long duration. Their problems derive from unhealthy parent-child relationships, or uncompromising and hostile community attitudes. The outward symptoms of the disorder may range from mild situational reactions to frank psychoses. Often the retarded is unaware of his inner feelings, behaving in an unpredictable and impulsive manner.

The problems outlined above are only a few of those common to the retarded which are subject to resolution by means of the casework process. Actually the adjustment problems of this group cover the total spectrum of social dysfunction. Whatever the nature or cause of the problem, however, its solution is generally accomplished through the medium of a meaningful casework relationship.

The essence of this relationship involves some interaction of feeling between worker and client, a joint concern for the client's problem and an atmosphere of trust, acceptance and helpfulness. It requires on the part of the client seeking help, a recognition of the worker's authority of knowledge and skill—a recognition which lends a feeling of security within the relationship and facilitates his use of guidance. On the part of the worker, the relationship requires a true appreciation of human dignity and integrity, a willingness to help, an expectation of the client's responsiveness toward a better social adjustment.

These elements are basic to all casework relationships, but their realization is frequently impeded when the client is retarded. For the most part, the retarded adolescent or adult seldom seeks help on his own initiative. Sometimes not only the retarded client, but his family as well, resent the intrusion of the agency's authority and are resistive to professional casework services. Some of these retarded individuals have come to regard all persons in authority as a source of punishment and persecution and are distrustful of interpersonal relationships.

Establishing rapport with these individuals is often difficult, but seldom impossible. Like his normal counterpart who has been traumatized in his striving for emotional acceptance and social interaction, the similarly deprived retarded person may demonstrate marked withdrawal symptoms and be hard to reach. Conversely some have had sufficient loving so that they continue to "reach out" for adult attention and affection. These individuals are quick to respond to a sympathetic and understanding attitude, sometimes to a point of fawnlike devotion that the worker may find embarrassing. Others will approach the caseworker with the same childlike innocence, trust and dependency they extend to all adults.

Whatever the initial capacities of the retarded person, the relationship develops as emotional experiences are shared and the worker demonstrates his identification with the problem and his competence to deal with it. Some of the retarded communicate their problems quite freely and simply, unembellished by elaborate rationalization and other ego defense mechanisms. Some blame their troubles completely on their mistreatment by parents, teachers or peers. And some do not disclose their problems, either from suspicion and distrust or from an inability to articulate their feelings. In each of

these instances, as with intellectually normal clients, the verbal participation of the worker in the identification of the problem will vary. The likelihood is great, however, that with retarded clients, the worker will need to be more actively involved in setting forth the focus of the interviews and will need to rely more heavily on non-verbal skills in conveying an attitude of personal interest and acceptance. The worker's demeanor, facial expression, tone of voice, body movements and participation in activities with the client are often more effective than repeated words of assurance and support. Most important, the worker must convince his retarded client that he (the worker) is trustworthy and that he has trust in him. Only as the client is secure in the relationship and a sense of mutual trust exists can learning and behavioral change take place.

One of the major obstacles to effective casework with these clients is the difficulty encountered by some professional workers in applying the basic tenet of all social work practice, that every individual has intrinsic human value. Underlying feelings tend to emerge in the casework relationship and these workers cannot conceal their exasperation with the retarded client's uninhibited and impulsive behavior. Neither can they escape the impact of cultural attitudes toward low intelligence or the sense of revulsion aroused in themselves and in most people by the grosser forms of human defect. Some workers demonstrate this aversion by denying retardation in their clients and attempting to make their clients over, in their own self-image as it were. In this way they are able to free themselves emotionally to form a helping relationship. These reactions of some caseworkers—to which other professions are equally liable—impede the identification process which is essential for psychological helping. It is *relatively* easy for the worker to conceive of himself as blind, crippled, neurotic, economically deprived or socially maladjusted. Few however, can imagine themselves as truly retarded.

No magic formula exists whereby these attitudes toward retardation can be readily changed. In this as in other areas involving attitudes deeply rooted in our system of social values, the need for an objective self-examination of feelings is paramount. The worker should neither overestimate himself as an individual nor have distressing feelings of inadequacy or insecurity in dealing with the "unknown quantity" of his retarded client. He needs an especially generous allotment of kindness and sympathy to identify with these persons—often the least endowed of all his clients. More precise knowledge of the retarted and their potentialities, through formal educational processes or through self-learning activities, can also help. Perhaps the mast effective approach in modifying attitudes is through a carefully supervised, successful work experience with a retarded client both on a student and practitioner level. With proper under-

standing of the "nature" of the client and convictions regarding his inherent worth and suitability for services, techniques can be properly adapted.

A fundamental principle in casework is the client's right to self-determination. Every individual, within the limits of reality has the right to be master of his own destiny. While the validity of this concept is undenied, its application in work with the retarded is necessarily limited. For this group, the limits of reality are not defined solely by the external environment but must also include the incapacity of the retarded to choose between alternative courses of action and to make decisions in his best interests. The "right" to act in a given manner has no real value for the individual who is unable to exercise reason and judgment and who needs protection from his own imprudence.

This does not mean that the retarded client is completely unable to participate in the problem-solving process, for those who are so lacking are not appropriate candidates for the counseling aspect of casework services. It does suggest, however, that the retarded client may have a limited grasp of the facts that bear upon his problem, may not fully understand their significance and may be unable to apply them toward a resolution of his problem.

To promote greater understanding where only partial understanding is evident, the worker will need to devote more effort to interpretation, extended over a period of time. Language must be consistent with the client's level of comprehension and specific ideas or suggestions must be re-enforced in succeeding interviews to insure carry-over. It is wise too, to test the client periodically for "feedback" to insure that communication has actually taken place. The retarded client, who is already burdened with a sense of his own inferiority, is apt to nod his understanding to preserve his self-esteem, when in fact the meaning of the worker's words has eluded him.

Even where the retarded client has or acquires some insight into the basis of his social difficulties, it cannot always be assumed these insights will be properly applied in future stress situations or important decisions. The objective of casework with the retarded individual is to promote his general adjustability, a highly feasible goal for most. But some of the retarded, while they are relatively *well-adjusted* or can be helped to become so, are not very *adjustable.* The well being of these individuals depends in large measure on a constantly favorable environment; they are apt to flounder under stress conditions. In these cases, the worker must rely more heavily on direct advice and guidance. He must act as the client's superego, imposing limits upon him which he cannot set for himself, and making decisions where he lacks the capacity to do so through his own powers.

Reliance on direct advice and guidance techniques is not con-

fined to the intellectually limited person, though it may be used in greater degree here than with other groups. This places an additional burden on the worker to know the facts fully, to carefully appraise his clients' capacities and limitations and to be able to anticipate with some accuracy the consequences of a particular course of action. This is indeed a weighty responsiiblity and it presents special hazards to the casework relationship.

The danger is ever present that if he is very frequently advised on how a problem should be handled, the client may become overdependent on the caseworker and lose all initiative in handling new situations as they arise. There is the further danger that the advice proferred may not result in a successful resolution of the problem. This tends to place the caseworker in a potential scapegoat role and to relieve the client of responsibility for the outcome. Often this is less risky than when the retarded client makes the final choice with little knowledge about what the worker thinks is best. Much depends on the problem at hand. The retarded individual who plans to quit his job with no reasonable prospects for a new one may be a case in point. His dissatisfaction may stem from legitimate causes—low pay, lack of social contacts with fellow employees and demanding work schedules. His discontents, however, may arise from an unrealistic appraisal of his own potentialities, his improper placement within the plant or his own unfounded attitudes of suspicion and distrust. In either event, the retarded client's assessment of the facts may be inaccurate and his solution thereby faulty. Freedom of choice—to quit, in this illustration—may not get at the basic cause of dissatisfaction and may in fact greatly compound the client's adjustment difficulties. The client needs the protection of the worker's superior knowledge, and where the worker stands in a position of authority—as in cases on trial placement from the institution—it may be well to invoke this authority in the decision-making process.

While these hazards are undeniably real, a judicious use of this technique, involving the client's participation to the maximum extent possible, can minimize any negative effects. Supportive therapy with all clients—in the initial period at least—presupposes some dependency on the caseworker, a dependency designed in the long range view to strengthen rather than weaken the individual psychologically. With retarded persons this dependency may need to extend over a longer period of time, but the sensitive worker will know when the client is prepared to act on his own and will modify his participation in the problem-solving process accordingly.

When alternate solutions are possible, and particularly when the consequences of a wrong choice would not be seriously harmful to the client, independent action should be encouraged. Given the opportunity to make his own decisions, the retarded individual is less able to

project blame on the caseworker. More important, should his judgment in a given situation prove effective, it will bolster his self-confidence and increase his adjustability. Even where his judgment is faulty, if the effects are not severe, valuable learning may occur and some long-range gains may ensue. In these instances, the casework relationship sustains the client and provides a setting in which previous errors can be analyzed and other methods of handling the problem identified without criticism by the worker or personal threat to the retarded client.

The caseworker should not approach every retarded client with the assumption that he is capable of only minimal participation in the problem-solving process. This capacity varies in all persons, even those with normal intelligence, depending on a complex of personality considerations. But this does not deny that, where other variables are equal, the individual of low mentality, poor judgment and impaired powers of reason, will need more direction in promoting proper social and emotional patterns of conduct.

The casework adage of "starting where the client is" has validity with retarded persons as with the normally intelligent, but is much more difficult to apply. Among the mildly retarded at least, the determination of "where the client is" is sometimes exceedingly complex. Often these individuals show a highly uneven rate of development in significant areas of growth. In the normal child, mental and chronological age coincide and are highly correlated with social and emotional development, though disparities are by no means uncommon. With the retarded these differences occur with greater frequency and are likely to be more marked.

Social workers are often puzzled as to the level on which to approach these youngsters and are further confused by parental reports of childlike interests, motivations and behavior. It is well to remember that in some cases, such interests and behavior are unwittingly fostered in the parent-child relationship and may not be a good index of actual growth patterns. For the most part, mental age is not a reliable guide to client readiness and casework techniques. The 16 year old child with a mental age of 10 is not like other 10 year olds. We cannot ignore the socializing effects of additional life experiences and the way in which family and community expectations influence the child's perception of himself and his range of interests. Social considerations embracing the whole range of the client's experiences, interests, motivations and capacities, must be evaluated in assessing the proper approach to treatment.

Low intelligence affects the caseworker's approach in other ways, too. The verbal analysis and appeal to logic and reason that characterize certain aspects of the casework relationship has limited application with the retarded. These individuals cannot reason ab-

stractly on a high level, grasp a complex idea, identify with a philosophy or ideal. They do, however, share the wide range of emotions to which all persons are subject. They can can be quite responsive to the emotional components in a situation, including, as we have already noted, the attitudes of the worker. Where strong feelings of loyalty to family or friends exist, appeal to these emotions may change the retarded client's attitudes or guide his behavior.

Unfortunately, in some instances, these bonds of affection are with persons whose conduct and character are unwholesome. Sometimes it is desirable to work toward a severance of these emotional ties. If the client can be freed of these attachments, the conflicts between the values of his family and those of the worker—representing the larger society—may be dissipated. In these circumstances, the worker may come to be viewed by his retarded client as a parental figure, and as a "parent" he will be endowed with authority and looked to as a source of security and guidance. When this occurs—a not uncommon phenomenon in counseling with the retarded—some degree of character reeducation may take place.

The suggestibility of some retarded clients, when they are motivated toward the social values of the caseworker, can prove an asset in character reeducation. Sometimes the retarded individual, especially the culturally deprived, exhibits antisocial behavior patterns because the meaningful persons in his environment have failed to teach him otherwise. To be accepted and loved, he must emulate his parents and siblings and he feels little guilt about his conduct because he has not incorporated into his conscience the moral codes of the community. In other instances, the lack of love from his own family compels him to seek acceptance from outside sources. The emotionally vulnerable retarded boy is thus sometimes "led into trouble" because he seeks status, recognition and acceptance that is otherwise denied him. The retarded girl, for the same reasons, may engage in sexual behavior. Both are driven to follow the suggestions of others—at least partially—by virtue of their unfulfilled needs and wants in their family relationships.

The casework relationship can provide an emotional experience for the retarded client wherein his needs for acceptance and security may be fulfilled. To the degree that these needs are satisfied, the client may be freed to use his intelligence (most of the mildly retarded can distinguish "right" from "wrong") in assessing the inappropriateness of a specific course of action suggested to him. As the worker demonstrates his support and unwavering acceptance, the retarded individual may modify his behavior to gain or retain the worker's approval. Here the worker is able to exploit the client's suggestibility to good advantage, to create new desires and to control existing ones. In offering suggestions, as with direct advice and guidance,

the worker should proceed with caution. He should be reasonably certain that the retarded client can act upon the suggestion and that it is an appropriate plan in the light of all the known circumstances. Properly used, this fairly common trait of the retarded need not be a social liability.

Another important consideration in casework with the mentally retarded is the need to stress their abilities, while at the same time they are helped to recognize their limitations. Most of the retarded who come to agency attention, have been exposed to a constant dosage of "don'ts" and "cannots." Their inadequacies prompt admonitions in the family, school and neighborhood about the things they should not do, and they are frequently reminded of activities they cannot perform or goals they cannot undertake. As a consequence, they regard themselves as "bad" or inferior. Equally important, while they learn what they should not do, they are given little direction about what modes of conduct are proper in certain circumstances.

The caseworker cannot and should not avoid identifying the behavioral difficulties of the client, for only as these are realistically faced can motivation for change take place. Neither should he evade discussion of the client's mental limitations, for only as the client's aspirations are related to his capabilities can he be protected from unnecessary and further debilitating failures. Nor can the worker realistically fail to admonish the client when a repetition of his behavior will further aggravate his maladjustment. The problem lies not in the interpretation and discussion of these factors, but in how the interpretations are made and the extent to which these negatives are dwelt upon.

The guiding principle in these cases, as with intellectually normal clients, is to preserve or build up the retarded client's self-confidence and esteem and to avoid further ego threat. Most retarded persons are already aware of their learning deficiencies, but they may fail to relate these deficiencies to certain job requirements because they do not know what skills or education are needed to perform various tasks. Pointing these things out can be initially threatening, but the effects can be tempered by reference to the variations in the physical abilities of people and by acknowledging the accomplishments of the client, no matter how limited they may seem. Probably every retarded person has some small skill or talent. The worker is well-advised to identify these abilities, emphasize them in discussion, and build upon them by arranging for experiences in which these skills can be successfully applied.

The tendency to stress the "don'ts" in behavior when working with adolescents or young adults is probably most understandable. Unhappily, no list of "dont's" can safeguard the individual against every contingency. Neither can these young people be expected to

exercise the controls such a list would entail in the absence of positive guidance, sex education, and adequate preparation for the channelization of behavior.

Many parents find the sex education of their retarded children beyond their comprehension. They fear the use to which such knowledge may be put or, like some parents of normal children, feel insecure in this area of child guidance. For related reasons, the schools, institutions and other training and rehabilitation facilities have also tended to overlook this basic educational need. As a result, the vulnerability of the retarded adolescent and young adult is heightened. He may not only lack inner controls and the opportunity for substitute outlets, but he is denied maximal use of his limited judgment because the "facts of life" have been withheld from him.

Sexual misconduct can be a serious source of social dysfunction and is in truth a major factor in the institutionalization of retarded girls above the age of 14. The caseworker can do much to safeguard these girls from exploitation by others and from their own uninhibited actions. Where the parents are the primary clients, the worker can help them decide what the retarded youngster can understand and what he should know about body functions, personal grooming and boy-girl relationships, and can encourage them to carry this educative function. If the parents cannot carry this function or there are no parents to do so, the social worker may help the retarded child with his knowledge and feelings about sex through the casework relationship.

In this process—whoever provides the instruction or treatment—discussion must be geared to the age and mental level of the individuals or groups involved. The subject should be approached casually and naturally, in discrete parts and with sufficient repetition to ensure understanding. To the extent possible, the discussion should be related to other aspects of the child's life, so that it does not arouse anxiety unnecessarily or focus undue attention on this phase of physiological and psychological behavior. For example, a general discussion of manners and consideration for others, can lead to an exploration of proper conduct at dances, parties and social hours, of what it means to "go steady," of how to meet friends. Emphasis on personal grooming and hygiene can provide the initial approach to menstruation and a later discussion of anatomy, secondary sexual characteristics, and the reproductive process. When the objectives are primarily instructional and conducted on a group basis, the use of visual aids and demonstration is highly desirable. In all of these areas, the "do's" in behavior should be stressed.

The retarded boy or girl who is given an intellectual grasp of the principles of sex development and behavior has a better chance to

exercise psychological restraints than one who is not so prepared. Knowledge alone, however, will not suffice for the youngster who misbehaves sexually because she is deprived in her affectional life or has identified herself with negative values in the home. These youngsters need help in finding other suitable outlets for their affectional needs and in developing a stronger moral conscience. Once rapport has been firmly established, a frank discussion of the problem may take place without fear of threat or personal rejection on the part of the retarded client. The consequences of such behavior must be realistically interpreted and limits set in terms of acceptable social norms. It is essential, however, that limits be reasonable and within the capacity of the client to abide by. Rigid controls destroy the retarded person's self-confidence and create the feeling that the caseworker has little trust in his capacity for self regulation. The worker must recognize that for the retarded individual in the community, constant supervision is an impossibility.

This principle is often overlooked in the supervision of mildly retarded girls released from institutional care in family or work placement. Strict curfews, restrictions against dating and other social activities are often rigidly enforced, with return to the institution as an ever present and verbalized threat. While such regulations may have value early in placement and even contribute to the security of the girl who may fear her own acting-out impulses, their prolonged application is often self-defeating. In practice, many of these girls tend to rebel against restrictions in dating and resort to illicit contacts, which frequently arouse much anxiety in all concerned and aggravate the girls' social maladjustment. Conversely, where greater freedom is permitted, there is less need for "behind the back" activities and as a rule fewer community problems are engendered. These results can hardly be guaranteed, and in each case the individual's capacity for self control must be determined. But we cannot expect the development of social maturity, independence and acceptable heterosexual relationships unless opportunity for the promotion of these skills is provided. Failure to educate and counsel retarded persons in this phase of life is apt to reap a host of social reprisals for him.

Adapting the environment

The problem solving process in social casework, while it strives toward making the retarded client more adaptable to new and changing conditions, cannot rely entirely on this unilateral approach. Some clients can be helped to become reasonably adjusted, but with others, successful adjustment will depend on how much the environment can be "tailored" to their social capacities.

In this regard, the need to modify parental attitudes is often overlooked, particularly for children in foster family care or in the rehabilitation of the institutionalized retarded person. For the mildly retarded at least, family or community pathology—and generally both of these—is usually the underlying factor necessitating separation and placement. The value of the foster family experience or the institutional program, no matter how effective it may be in promoting social skills in the retarded individual may be largely lost if he is returned to the same pathological environment that contributed to his maladjustment in the first place. If the conditions in the home are basically unalterable, return to the family is contraindicated. If the community from which he originally came is too intolerant, demanding, disadvantaged or complex, a more favorable community for placement must be found.

The importance of adapting the environment to the needs and capacities of the retarded client, and the consequences to the client when this is not done, are clearly illustrated in a study of population movement by Windle. (45) Sixty-three percent of those returned from the institution to their own homes who failed in placement, failed because of antisocial behavior—crimes, sexual misconduct, pregnancy, minor antisocial actions. The reluctance of the family to seek professional intervention until "too late" and the less intensive responsibility of the social worker for individuals in the care of their own parents, partially explain these failures. But the most important considerations are the unchanging nature of the home, the lack of environmental supports, the inadequacies of parental supervision and guidance.

By contrast, placement failure in the moderately retarded stemmed largely from intolerable behavior—untidiness, temper outbursts, hyperactivity, destructiveness, etc.—or from medical problems requiring extensive care. The foster parents in whose homes these individuals were placed were often unequal to the tasks posed by the care of these children. In some instances, they were further handicapped by community objections or by interference from the child's natural parents.

Failures in vocational leave were due, for the most part, to poor work performance, difficulties in interpersonal relations and by voluntary departure from the work situation. Frequently these factors are interrelated, the anxieties and emotional problems of the individual being reflected in his work performance. With this group, partly because of the careful selection process preceding placement, antisocial behavior is far less frequently observed than in those returned to their own homes.

The need to modify parental attitudes and behavior and to improve home conditions before or while the retardate is in his own

home is obvious. Satisfactory adjustment of the retarded in the regimented, controlled environment of the institution, does not guarantee similar behavior outside. Casework treatment therefore, must be directed not only toward the retarded individual but toward his family as well. Sometimes the needed professional casework services to the family can be provided by the institutional staff; more often the family's distance from the institution and the worker's unfamiliarity with local conditions makes the assumption of this responsibility by local social agencies more feasible.

The difficulties encountered in the foster family placement of moderately retarded children further highlights the importance of adapting the environment to the special needs and capacities of the child. Foster parents of retarded children must be carefully selected and need to possess exceptional personal qualities. The community, too, must be reasonably accepting and provide at least minimal resources for social and recreation activities. (These considerations will be discussed in greater detail in Chapter VI.)

It can be seen from these brief illustrations, that the problem solving process may proceed in three major directions: (1) strengthening the retarded person's adaptability, (2) modifying the environment by effecting change in attitudes and expectations, and (3) carefully selecting an environment especially suited to the retarded individual's needs.

In the rehabilitation of the older adolescent, particularly those for whom social and vocational independence is the goal, the caseworker will often need to consider all three components. Though many of those identified in the school program as mentally retarded may not need casework help in the transition to adult life and the responsibility this entails, the socially maladjusted often do. Vocational training and guidance for these youngsters can provide the tools needed to compete in the labor market, earn a livelihood, gain in self-confidence and derive the emotional satisfactions of self-support. But before work skills can be effectively applied, retarded persons must learn how to get along with others, to accept authority, to be reliable and dependable and in other ways to adjust to the demands of the industrial setting. Some of these attributes can be acquired in the process of vocational training but frequently the factors contributing to social dysfunction must be resolved through casework and other therapeutic procedures.

Assuming that these ends have been achieved to a reasonable degree, the task is not yet complete. The mentally retarded cannot be expected to know what job opportunities are available, what kinds of work they can do, where they can seek help in job finding and how to apply. In these pursuits, they often need much guidance, direction and concrete assistance.

In some instances the real problem lies not in the personal or work inadequacies of the retarded, but in the attitudes of prospective employers. These individuals frequently underestimate the work skills of the mentally retarded and stereotype them unjustly as unreliable and untrustworthy. To ensure the retarded a proper chance to "make good" on the job, or indeed get a job at all, these attitudes need to be overcome. Public education through mass media and more direct, interpretative contacts with business and other employer associations, can appreciably alter attitudes and expand work opportunities for the retarded as a group. For the individual retarded person, however, the caseworker is often well advised to contact the prospective employer directly with the full knowledge of the client. This offers the opportunity to assess the work situation in relation to the client's skills, to explore the employer's feelings toward an understanding of the mentally retarded and to interpret the client's aptitudes and other considerations relative to his work performance. Equally important, an offer of continuing casework help, should adjustment problems arise, can often allay the employer's anxieties and encourage trial placement. The involvement of the employer as a partner in planning a productive work experience for the retarded client and the worker's shared responsibility for supervision and guidance in the area of interpersonal relationships, are vital elements in the placement process. In this way, the demands of the work situation, within the limits prescribed by the setting, can be adapted to the abilities of the retarded client.

Some settings—highly automated factories for example—may be too complex in organization and too demanding in technical skills, to be used as a placement resource for retarded persons. Similarly, industrialized metropolitan centers may present daily living problems and potentially undesirable influences that exceed the adjustment capacities of the less capable retarded individual. Other social institutions, too, cannot be readily adapted, modified or manipulated to accommodate them. In these instances, the environment in which they are to live must be inherently less complex and demanding.

Apparent differences are evident between rural and urban communities, though these differences are becoming less marked with the mechanization of farming and the gradual absorption of the small farm. Nevertheless, the expectations of a backwoods rural community are less exacting than those of a large metropolis. Many formerly well adjusted retarded children and adults who move from a rural to an urban setting become maladjusted in the large city. Standards for school achievement are higher, job requirements and qualifications more exacting, and the system of social relationship more complicated. The retarded individual of low marginal abilities, who must rely on his own resources for subsistence and otherwise inde-

pendent functioning, is sorely taxed by the demands of urban living. The problem of fitting the environment to the retarded individual whatever the degree of handicap, is less crucial when acceptance, understanding and supervision from responsible adults are provided. Under these conditions, even the moderately retarded—as reported by Saenger—have adjusted surprisingly well in that most complex of urban settings, New York City. (21)

Most of the retarded needing casework services to relieve problems of social maladjustment can be helped to achieve adequate solutions while living in their own homes, in foster family care, wage homes or independent living arrangements. For the few who lack impulse control and whose behavior is unmanageable and constitutes a threat to society and to themselves, however, the more controlled environment of the institution may be indicated. In this setting, a retarded person can be protected from the traumatic consequences of his antisocial behavior and can be freed to adopt a new orientation toward life. Here, he may be able to discard the values of his impoverished culture and establish a solid foundation of practical knowledge to prepare him for later return to the community. With the help of the caseworker and other therapists, he may once again learn to trust others and have confidence in his own capabilities. Properly applied, the institutional program of education, work training, recreation and group living, can complement the problem solving objectives of the casework process.

The caseworker in the institution is sometimes initially handicapped in his efforts at treatment by the retarded person's lack of preparation for separation from his family and community. These youngsters—usually mildly retarded and between the ages of 14 and 19—generally are institutionalized against their will. Their involuntary loss of freedom does not inspire trust in their strange surroundings and they regard the institutional personnel with hostility and fear. These reactions are sometimes further compounded by the court or caseworker's interpretation that he is being sent to the institution for more learning or specific job training with no reference to his behavioral conflicts. Many of these youngsters recognize these interpretations as half-truths. They tend to be resistive and disinterested in education in a "new school" when they have already attended school for many years and may, in the case of the older adolescents, have reached a stage of educational saturation or insensitization. They may also regard with suspicion an offer of job training when their parents, siblings and acquaintances have managed without such experiences. The indefiniteness of their commitment is looked upon as "unfair." Most important perhaps, the retarded youngster generally knows full well that his behavior is the primary basis for his placement. Failure to interpret his need to change his behavior pat-

terns and for guidance in this area will be recognized as an evasion. It may heighten his sense of distrust, and perhaps minimize his feeling of "wrongdoing." Whether prompted by insecurity or by an unwillingness to be a bearer of sad tidings, the caseworker who avoids the reality factors resulting in the commitment can be guilty of a disservice to the client. The problem must be squarely faced, without punitiveness, if motivation for behavioral change is to result.

Ideally, treatment for these retarded youngsters starts on the day of arrival. The caseworker conveys an atmosphere of helpfulness and acknowledges and accepts the child's anxieties and possible resentment over separation from his family. The program of the institution is explained and concrete examples within the child's daily institutional experiences are used to make clear what is expected of him and thus protect him from exploitation by others or his own misconceptions. In this setting, as in other agency settings, the casework relationship places as much responsibility on the client as appropriate and tries to encourage a sense of independence in him. To the extent that the social worker formulates or contributes to policy development, efforts should be directed toward liberal "leave" regulations. These temporary visits to the community are vital elements in training for responsible independent living. Equally important, through such opportunities the child's hopes for reunion with his family or community placement are kept alive and he comes to view his institutional experience as something constructive rather than as confinement against his will.

The goals of social work in residential programs for the retarded are comprehensive and may include elements of staff development, administration and research, as well as group work and the more traditional casework functions with the retarded and their families. (46) However extensive these functions may be, all are directed to the ultimate goal of enhancing the social functioning of the individual and his family. These activities are particularly pertinent to the mildly disturbed, "acting-out," retarded individual whose social deficiencies are the basis for his admission.

The remediation of these deficiencies cannot usually be accomplished solely by further education, work training, occupational therapy and similarly oriented programs. While it is essential that retarded persons acquire the practical skills of daily living that these programs try to instill, attitudes of resistance, low frustration tolerance, immaturity and other personality conflicts must be handled. Indeed, unless these barriers to learning and ego development can be overcome, the retarded individual is unlikely to profit from the formal program provided. Attempts at training before he is confident that others really want to help him may result in failure.

The social worker in the institution, having communicated his

acceptance and understanding of his client's problem and a willingness to help him help himself, is then able to act as the retarded person's social conscience. It is the worker's task—shared in some measure by other staff members—to interpret society's demands and to insist that certain norms and standards be followed. Repeated explanations are often needed to make these standards clear and to convince the retarded client that conformity, not rebellion, is to his advantage. The sensitive worker will exploit his unique role as advisor, confidant and trusted partner in problem-solving. In the impersonal institution, he can be an island of security, the person to turn to when things go wrong and personal worries seem overwhelming. His work with the family and his liaison functions with the community—particularly in the placement program—represents to the retarded person an important link with his familiar past and somewhat uncertain future.

To make the future more hopeful, the worker needs to be readily available, not only through formal office interviews, but through many opportunely casual contacts, to deal with the retarded individual's misgivings, fears and helplessness. Punishment, when called for, must be geared to the personality of the offender, rather than administered routinely according to the severity or nature of the offense. Above all, the worker must be constantly supportive and not re-enforce the lesson learned by many retarded youngsters that the consequence of misbehavior is loss of love and assistance. In this way the retarded client may gain a better understanding of why he acts as he does and feel—perhaps for the first time—that he has been treated fairly.

The social worker must always keep in mind the treatment goals of the institution and the importance of motivating the retarded toward self-improvement. Segregation from community life, while it is sometimes necessary, frequently does not have the rehabilitative effects expected of it. If the environment is too rigid and regimented, if there is no responsibility for self-management, if demands are geared to the less capable residents of the institution, the retarded individual may downgrade himself in his own eyes and respond at a level beneath his potentials. These potential effects must be counteracted if he is to adjust eventually to the social demands of ordinary community life.

Casework with the retarded then, in whatever setting it may be applied, rests on the fundamental principles which govern casework with other clients and utilizes, with some modification, similar concepts and techniques. Unquestionably, intellectual factors impede the problem-solving process and complicate the retarded person's adjustment, but the total complex of personality factors—in the mildly retarded, at least—are the primary determinants of his fate. The personality of the retarded individual, as with other persons, evolves from the inter-

action of his constitutional endowment and the physical and social forces which surround him. The dynamics of this interaction can be altered through professional intervention. In this task, the social worker can contribute significantly by enabling the retarded person to become more adjustable or better adjusted and by "tailoring" the environment to his abilities as well as his limitations.

chapter V

SOCIAL GROUP WORK FOR THE MENTALLY RETARDED

Social Group Work With the Parents

IN RECENT YEARS, group counseling programs for parents of retarded children have mushroomed around the country. The organization of parent groups, and the increased willingness of the members to be identified as parents of retarded children, has markedly increased the possibilities of bringing them together for educational or therapeutic purposes. Various approaches are used other than the social group work method and these group sessions take many forms. On occasion capable parents have acted as discussion leaders. Sometimes the choice of group discussion leader is arrived at indiscriminately; but frequently general, but vague, criteria are applied relating to the content to be discussed, the method of presentation to be used, and the objectives to be reached. Unfortunately, in many instances, groups are organized spontaneously, without full recognition of the role of the leader or with insufficient understanding of the nature of group dynamics, the use of the group process and the factors which govern selection of participants. Since group interaction—including the influence of the leader upon members of the group—is the medium through which attitudes are changed and learning and treatment takes place, these are important considerations.

At the present time, a wide range of parent counseling programs are being supported under a variety of auspices—diagnostic clinics, day care and nursery centers, sheltered workshops, public and voluntary residential facilities, parent associations, and church groups. These programs are for the most part at an embryonic stage of development and remain to be fully evaluated before their overall

merit can be specified and their techniques more generally applied.

Schools of social work are one of the very few resources that provide special training in the use of the group process to enhance the individual's capacities for social living and to accomplish certain related goals. The social group work method utilizes group interaction, consciously guided, directed and influenced by the social group worker, as the force through which individual growth and development takes place and through which the attitudes and values of each member may be affected.

To carry out the objectives in this definition, the social group worker needs a thorough understanding of personality dynamics and human behavior. He needs diagnostic skills in assessing the individual's capacity to profit from group participation, an ability to use group dynamics and methods constructively, and a capacity to understand and deal with his own feelings. It is a basic principle of social life that when persons sharing similar interests and problems are brought into meaningful contact with one another over a continuous period of time, they mutually influence one another. This, along with the professional social group worker's use of himself, is the essence of the social group work process. It is thus distinguished from other "group approaches" such as when a loosely structured, constantly changing group of parents get together among themselves to share experiences or to participate in lecture-discussion sessions for informational purposes. Similarly structured groups include social gatherings, orientation meetings to interpret the agency's program, regulations and procedures, and professionally guided workshops for parents. All of these approaches can be useful and may have indirect treatment value in the sense that knowledge may change attitudes and shared experiences may relieve a feeling of aloneness and self-pity. Yet these effects are often largely the uncontrolled by-products of this type of group interaction and the impact on individuals is not only unpredictable but may be detrimental to some.

The values of the social group work method are not limited to the treatment goals noted above. Group interaction can supplement other diagnostic techniques by revealing problems which the parent, because of his insecurity, is unable to communicate in a one to one relationship. It may accelerate the initial step in treatment, cast new light on parental attitudes and provide clues to future treatment needs.

Group counseling of parents, in the context of the process described here, offers certain values not duplicated in the casework relationship. When parents have the opportunity—under professional guidance—to share experiences, anxieties, problems and solutions with others similarly involved, their guilt at having created an imperfect child seems less personal and their sense of inadequacy in meeting the problems presented, less embarrassing. They are able

to derive some comfort from the knowledge that others are also struggling with problems of toilet training, speech development, discipline and management, sexual behavior, and future planning. And they may be greatly encouraged as they learn that others have found successful solutions to seemingly impossible problems. The chance to share their burdens often provides a new perspective of their individual situations, promotes a sense of belongingness and combats tendencies toward social withdrawal.

Selecting group members

In the use of the social group work method in work with parents of retarded children, it is essential that the social group worker have a full understanding of the meaning of retardation to parents and its real or potential impact on family life. Obviously, not all parents are equally affected by the presence of a retarded child, need professional guidance, or can profit from structured group experiences. Even where children have similar handicaps, relative homogeneity among them does not guarantee homogeneity among their parents.

Criteria regarding the degree of homogeneity desirable for effective group participation must await further experimentation and refinement of evaluation procedures. Our limited experiences thus far indicate a wide diversity of opinion and practice. Some writers contend that "groups soon develop a homogeneity of their own, the members becoming quite supportive of one another." (47) Others believe that a degree of homogeneity, based on the similarity of problems encountered, is a useful basis for grouping, as when all the children have an etiology of mongolism. (48) Still others suggest that the parent of low socio-economic status and a deprived cultural background is uncomfortable, insecure and passive in a group of articulate parents accustomed to sharing their views in civic and club activities.

The wide range of conditions and capacities among the children themselves raises additional questions in determining group composition. Can the parents of a school age, mildly retarded child, concerned with problems of social behavior, boy-girl relationships and opportunities for group companionship, benefit materially from a group discussion with parents of a severely handicapped child whose activities are confined to the family circle? Can the parent of an older retarded child who has resolved many of his emotional conflicts, but wants help in the use of leisure time or work training, find help in parents who are "just starting out" and are absorbed with deeply felt anxieties and concerns? Does the question of the child's whereabouts—home, foster family care, institution—have a bearing on the group process as a treatment tool?

Ready answers to these questions are not yet available, but these illustrations do suggest that in the development of guidelines for group formation, a number of variables must be considered. If the social group work method, like casework, is to be oriented to problem-solving, then the persons involved must be able to identify themselves with the problem—through interest or experience—and have a capacity to contribute actively, or share passively in the solutions reached. The problem itself, and the readiness of the parent to deal with it in the group situation, must be determined through careful psychosocial evaluation. These will depend on factors related to the child, such as age, degree of handicap, behavior, and sex, and to the family, such as emotional adjustment, values, length of experience with problem, intelligence, and status. These criteria cannot be rigidly applied and some degreee of divergence is probably inescapable, and indeed desirable in order to broaden the group's dimensions and enrich its thought content. How much divergence is possible without seriously threatening group goals depends in part on the number of sessions planned, whether membership in the group is closed or open, and whether goals are primarily educational or therapeutic. In effect, however, these are often so interrelated as to be indistinguishable. Short-term groups, for example, are not likely to realize treatment objectives if interests, needs and capacities are diffused. Definition of the problem and the clarification and solidification of group thinking and feeling takes time. Conversely, the larger the group and the longer it meets, the greater the tolerance for individual differences. In these groups, the "different" member is more easily absorbed and the absence of one member or the addition of new members does not interfere markedly with group continuity and interaction.

Perhaps the most important consideration in the selection of group participants—by interdisciplinary determination, if possible—is the personality of the parent. The treatment-oriented group process is not appropriate for all parents. The parent who is immature or completely overwhelmed by the nature of his problems is more likely to benefit from a one-to-one casework relationship. This is generally true, too, for the overly aggressive, uncontrollably hostile person whose behavior is disruptive, and for parents with severe emotional disturbances—*unless perhaps the objectives of the group are intensive therapy and highly skilled leadership is available.* Inclusion of the overly anxious, very timid or less adequate parent, can be considered when it appears likely that the group can accept such a member, and group functions would not be unduly hampered.

While the above considerations apply to both parents, the desirability of including fathers in the formation of parent counseling sessions is frequently overlooked. Fathers, because they are fre-

quently less involved in the direct care and management of the child, often find it more difficult to accept the diagnosis of mental retardation and are prone to disguise their true feelings. Their exclusion from individual or group treatment—whether due to their inaccessibility or to professional oversight—tends to place the fathers in the position of "outsiders" looking in. Denied the opportunity to take part in the problem-solving process, the burdens of child care are not likely to be fully shared by them, and parental inconsistencies, if they exist, may be reinforced.

Fathers, for the most part, do want to be included in planning for their children and could profit from the same treatment afforded mothers. The participation of both in the same treatment group need not be a deterrent to constructive group interaction though some practitioners report that the separation of parents into different, but heterosexually composed groups, promotes greater freedom of expression. Where parents are in the same group, initially the more verbal parent may act as spokesman for both. But with the support gained from other couples, and with the help of the social group worker, each parent in time usually feels free to express his own views, even when in disagreement with his spouse. The opportunity for spouses to clarify their own thoughts in a climate of intellectual freedom and emotional support may place their differences in a less personal light and enable them to view the problem more objectively, and perhaps with greater agreement. Though various plans for grouping mothers and fathers are possible, it is highly desirable, and in many cases essential, that the latter be included in the treatment process. Where severe marital friction exists, inclusion of both parents in the same group is generally unfeasible. Here too, diagnostic considerations are paramount in the selection process.

Structuring the sessions

The effective application of the social group work method rests on a number of factors: the knowledge and skill of the social group worker, the clarity of purpose and motivations of members, the composition of the group, and the formal or informal structure of its organization. Additional factors relative to the size of the group, the length of its sessions, the period of time between sessions, how many times it meets, and the physical setting in which meetings are held, are also important.

In planning for discussion groups with parents of retarded children, it is usually desirable to strive for a balance of formal and informal interaction. These parents are often looking for information and guidance in handling the daily problems posed by their retarded child. They look to the social group worker as a fountain of

knowledge and authority and derive security from his professional status and competence. Even when solutions are not readily available from the leader, the parents may still benefit from the recognition that their own inadequacies are not the basis of their problems. Leadership of the group discussion by an acknowledged, competent and experienced person, influences the contribution of each member. The problem-solving process in these instances tends to assume a logical, rational approach and the intellectual and emotional energies of the participants are consciously channeled toward common goals. This commitment to group objectives is carried out through the individual's awareness of his own role and through cooperative effort. Frequently this results in a corresponding restriction on individual liberty.

Because parents of retarded children often bring to the group sessions personal anxieties and tensions which need release, opportunities must be provided for free and spontaneous interaction on an informal level as well. Through such opportunities, feelings may be ventilated, experiences shared and group thinking crystallized. In the process, problems specific to the individual or common to the group become clearer, and ways of working them out through appropriate formal channels can be initiated. Such informal interaction between the members during the group meeting enhances and supports the formal structure. Parents are thus able to seek solutions in the group process under responsible, professional guidance, rather than through the more dubious and devious channels of the totally informal group structure.

Considerations regarding size of group, meeting length, and spacing of sessions, are governed by the same principles that apply to groups in general. Groups concerned primarily with educational purposes can accommodate larger numbers than those with primary treatment goals, though in both instances the extent of individual paticipation tends to decrease as size increases. There is some consensus that individuals cannot sustain relationships with more than ten or eleven persons at the same time and that groups of more than twelve tend to break down into cliques or subgroups. Where group cohesion is essential and members are highly dependent upon each other for the fulfillment of certain needs, as in small treatment groups, to have more than 12 people may be self-defeating. Six to ten is the optimal range for an effective discussion group. "Educational" groups on the other hand, may take as many as 20 or 25 persons and still engage in productive, goal-directed activity. Beyond this number, the therapeutic overtones arising from most discussion groups involving "troubled" parents tend to diminish. The less intimate atmosphere of the large group inhibits free expression, particularly in timid or less articulate parents, and makes it more difficult to focus group thinking and to identify problems of common concern.

Practice varies considerably with respect to the number of sessions planned in a discussion series, though as a rule each session ranges in length from one to two hours. Occasionally a single group meeting is planned, but these are largely for informational purposes and there is little effort to ascertain the group's needs or to involve the members in problem-solving functions. The objectives are set by the worker and are primarily interpretive in nature; communication and interaction between members is at a minimum. Sometimes however, a preliminary survey or the formation of a parent planning committee can reveal needs and lend additional focus to meetings.

The educational or treatment goals of the group offer the best guides as to the number of sessions to be planned. Whatever number is decided upon, it is generally unwise to change it. Knowing that the discussions will be terminated at a specific time helps define group expectations and stimulates a task-focused approach. When the series is "open-ended," attendance may begin to taper off and interest decline with a resulting loss of morale for the participants. If the group needs have not been adequately fulfilled in the prescribed period and resistance to termination is evident, then a new series should be arranged.

Some writers have reported fair success with three sessions spaced at monthly intervals, but this may have been due to the relative homogeneity of both the parents (articulate, largely middle-class) and their retarded children (mongoloids, aged one to four years). (48)

Generally, six to twelve sessions, held weekly or semi-monthly, are more appropriate to the full use of the group process. This allows enough time between meetings to "try out" new approaches to problems, but at the same time insures some carry-over and a sense of continuity. Equally important, it heightens the feeling of belongingness of individual members, strengthens their identification with group goals and reinforces the influence of one upon the other. To maintain the advantages of the extended series, closed membership is preferable. People who join the group sometime after it has been formed have missed the dynamic interaction that characterizes the early phases of group discussion, as well as the subject matter covered. Their presence may be regarded as an intrusion, and may temporarily at least impede group movement. If newcomers are to be admitted, even the spouse of a group member, it should probably be done no later than the second or third meeting of a ten or twelve session program. These suggestions apply largely to treatment groups. Greater flexibility is possible in educationally oriented meetings.

In planning sessions, thought should also be given to the physical setting in which the meetings are to be held, and to the practical problems in parents' attendance. The meeting room should be readily

accessible to transportation and its decor should provide a relaxed atmosphere, conducive to free and informal communication. Agency facilities and community centers are some of the possible resources. Where facilities permit, it is often helpful to provide a playroom and adult supervision for the retarded children while the group is in session. Often parents encounter difficulty in hiring "baby-sitters" and even when they succeed, they sometimes feel uneasy about leaving the child for several hours at a time. Having the child cared for in the same building by competent adults can relieve them of anxiety and enable them to concentrate more fully on group tasks.

Applying the group work method

The social group work method is useful in dealing with content and feelings about a wide range of subject matter—from the presentation of facts about retardation and the discussion of management problems to the exploration and change of attitudes. Wherever the discussion group may focus along this continuum, the problem-solving process is centered around problems arising from the child's handicap. The parents may have many unresolved problems unrelated to their child's condition, such as marital tensions, which affect the parent-child relationship, but these problems are best handled through casework or other therapeutic procedures. The common bond which brings these parents together and without which they would lack group cohesion is the handicap of their child and the feelings and problems resulting from it. Failure to focus on retardation and its attendant problems, as it affects the child and his interaction with the community and the parents themselves, would soon destroy the group's identity and dissipate its energies.

To maintain this focus and direct the group toward its avowed tasks, the social group worker needs more than an understanding of leadership theory and techniques, group dynamics and behavior. He needs in addition a thorough knowledge, to which physicians, psychologists and others can contribute, of the handicap and its many ramifications. Parents want to talk about their reactions when they first become aware of their child's handicap, how to meet his daily needs, manage his behavior, plan for his future care. They want information about community resources. Only as the worker is fully conversant with the problem can he be sensitive to the needs expressed and guide the group toward appropriate solutions. While he cannot be expected to know all the answers to questions posed, his influence on the behavior and attitudes of the group and his role in communication will be seriously curtailed if his lack of expertness is evident. Knowledge of "content" and "process" are both of great importance in the effective conduct of group discussion.

The extent of the worker's active participation in the group's discussion must be geared to his diagnosis of the needs of members, their level of sophistication and their overall knowledge and experience of the subject under consideration. While success has been reported by workers who have assumed a non-directive role and by others who have been quite directive, most group members seem to respond best to something in between. The worker who constantly redirects questions to the group, who is unwilling to express a personal opinion and who allows weaker members of the group to be attacked by an overly aggressive participant, runs the risk of generating group hostility and diverting the group from its objectives. True, groups frequently develop a capacity of their own to handle their troublesome members. This capacity needs to be encouraged, but the sensitive worker can expedite this process or intervene if group pressures remain immobile and the integrity of the group is jeopardized, or attacks on a member are injurious to him. Similarly, if the worker sidesteps parental concerns and charges the group members to resolve their problems without sharing his professional knowledge and experience, the members may become insecure, hostile, and restless. They may justifiably feel that nothing is being accomplished and their motivation for continued group attendance may subside.

Conversely, the worker who answers every question interferes with group interaction and communication. The parents are excluded from the problem-solving process and gain little from the experience that they can carry over into their daily problems of social adaptation. These parents are greatly in need of facts, but they also need acceptance, reassurance and self-confidence in facing the future. Such support is the unique contribution of the group, but it is made possible only when communication is free and emotional energies are properly channeled by skilled leadership. To guide, encourage, limit or redirect the expressions of parents, the worker must be able to assess the effect of individual statements on the person making them, on the total group and on individuals of the group. He must be able to recognize when an emotional outburst is helpful and when it is damaging; which personal disclosures enable a parent to deal with his frustrations more effectively and which are potentially anxiety-provoking and embarrassing; when to discourage discussion that may lead the group to an unwitting probe of unconscious motivations and conflicts.

The techniques utilized by the social group worker with parents of handicapped children are similar to those used with other groups. In the application of these techniques, however, the worker must not only understand mental retardation but must have a positive philosophy toward retarded children and a conviction that something can be done for them and for their parents. As in all aspects of

social work practice, he must respect the personal integrity of each parent, whatever his capacities to deal with, or his reactions to, his problems. If he fails to appreciate individual differences among parents and stereotypes them all as guilt-ridden, anxious, insecure or overprotective, he is apt to misinterpret what is being said and thereby impede problem-solving functions.

Social group work services to parents need not be limited to the discussion method described above, which may in fact be an inappropriate technique for some of the uneducated, culturally disadvantaged, or mentally limited parents. These parents may lack verbal skills and are often unaccustomed to this way of dealing with their problems. Furthermore—especially where the child's mental limitations are unrecognized by the parents—there is little motivation, or perhaps strong resistance, to help. Often there is distrust of the professional community.

Unlike parents who share common concerns, interests and goals for their retarded children, the socio-economically deprived family with a culturally retarded child is not a "readymade" group with a common bond deriving from the child's handicap. The social isolation of these parents makes them inaccessible to group methods through the usual channels and they frequently come to agency attention for reasons other than the child's retardation, except perhaps in the public schools, state institutions, and some mental health clinics.

With the increasing expansion of services to these youngsters in recreation programs, day care centers, and sheltered workshops, greater opportunities for bringing these parents together in groups are becoming available. The future development of special projects in foster family care, "half-way" houses and other group care facilities, should make these parents even more visible and—hopefully—accessible.

Although there is very little social group work experience with these parents to draw upon, casework activity with these families suggests the need for a different method and focus than with other families. Because retardation is not acknowledged, the child's developmental needs as a handicapped child must be approached tangentially, by raising the standards in the home and strengthening the parents' child-rearing capacities.

The social group work method offers a potentially excellent medium for the achievement of these objectives. Many of these parents—we have already noted—are basically devoted to their children, but are overwhelmed by the task of raising a family and are poorly informed regarding the fundamentals of family life. Their failure to measure up to community expectations is further cause for their rejection and social isolation. This in turn presents additional obstacles, for as these families find themselves outside the mainstream

of community activity, their motivation for self-improvement is diminished. Lacking the resources to handle difficult social and economic needs and caring little what their neighbors think, chronic maladjustments frequently prevail. In this complex pattern of family life, the limited abilities of the retarded child and the conflicts to which this may expose him outside of the home are part of the constellation of multiple problems encountered.

The ultimate objective of social group work service to these parents is to provide for the retarded child a climate conducive to his maximum development. The deprivation of these children provides the rationale for bringing their parents together and testifies to the need on the part of the worker to keep the child's interests always uppermost in mind. The immediate objectives, however, are to develop practical skills in the mother in the art of homemaking, and in both parents, in the art of child-rearing. Obviously, while these goals are interrelated, the content to be taught, the problems to be resolved, and the methods to be used must be designed and adapted to meet these parents' needs for education, reassurance and motivation. Frequently this will differ from the discussion approach employed with other parent groups, but in all instances, this should rest upon individual evaluation.

Various persons, including social caseworkers, homemakers, home economists, and public health nurses, have been engaged in teaching individual mothers how to manage their households, budget their finances, plan and prepare meals, improve health conditions, and care for their children. But when progress does not take place because the mother is unmotivated to learn and change, the group process may offer some plus ingredients. Through the medium of group interaction, the culturally disadvantaged mother can develop a sense of belonging and become a more active participant in functions outside the family circle. She receives recognition for her achievements and the group develops its own standards against which she can measure her own shortcomings. Usually she is encouraged to try harder in order to gain acceptance and approval.

In a recent Iowa project, conducted under the leadership of a home economist and supplemented by services on an individual basis from a social worker and a public health nurse, the values of the group approach were clearly illustrated (49). A group of culturally deprived mothers of low intelligence and socio-economic status were brought together (after being motivated to meet through personal contacts), for teaching and discussion sessions in several areas of homemaking. Meetings were held in the homes of the members. The children of these mothers attended a special day school project to demonstrate the effect of early training on their intellectual and social

development. The school's PTA served as a nucleus for the organization of the parent group meetings.

The study reported that as mothers were helped to develop skills in sewing, cooking, and other housekeeping duties and as they received praise for their achievements and were accepted and encouraged by the home economist, the other professionals, and the neighborhood women, constructive changes took place. Not infrequently these improvements eliminated conflicts between husband and wife. Freed of these tensions, "inadequate" parents were given a considerable boost toward the better discharge of their responsibilities.

The implications of this project for the application of the social group work method are many. The disadvantaged parent needs training in those practical skills that will enable him or her to be more proficient in the management of daily responsibilties and problems. He needs to achieve, not fail; to be encouraged, not coerced; to belong, not withdraw. The fulfillment of these needs through actual demonstration of what can and should be done would appear to be more effective than verbal persuasion, interpretation, or appeal to reason, but more experimentation is urgently needed. The group process offers a ready, but still largely unused vehicle, for helping these parents toward a higher level of social performance.

Social Group Work With the Children

The use of the social group work method with mentally retarded children, because of their varying degrees of intelligence and social competency, requires a differential use of the method in a variety of settings. Some of these methods are reported in the literature. (50) For those with a relatively wide range of social and verbal skills, for example, discussion may be utilized as a major medium of help and thus the method may not differ significantly from that employed with intellectually normal individuals. For the less able individual a specific program such as recreation, occupational training, or sheltered employment may be more helpfully utilized. In these instances, the program itself rather than group discussion per se provides the primary medium for group interaction. The conscious use and direction of the program to promote social skills is the tool by which the group worker affects social interaction and promotes communication towards stated objectives.

Among the retarded population, perhaps only the severely retarded lack the capacities to profit from structured group work activities in the sense defined earlier. The moderately retarded cannot be so disregarded. This group, frequently excluded from school

and from the other developmental group experiences provided for normal children, are excellent candidates for social group work service.

The moderately retarded

Moderately retarded youngsters are often exposed to unhealthy family environments. They are the "have nots" in our culture and unfortunately the "have nots" are not readily accepted by their family, peers, or the larger community. Too often they are protected even beyond the limits dictated by their handicaps and their dependency is unnecessarily prolonged.

For these children, the group process has many advantages. In many cases it offers the individual his first opportunity to direct attention away from his own shortcomings and to feel less unique and stigmatized. Knowing he is accepted and approved by his similarly handicapped peers promotes in him a feeling of security and satisfaction. Perhaps for the first time, he can feel free to act out hostile impulses without fear of punishment or severe censure by an adult. In the group process he may learn something of the subleties of human relationships, the give and take of social intercourse and the satisfactions to be found in minor achievements.

Casework or psychotherapy frequently has less to offer the "trainable" individual because of his poor verbal ability and comprehension, and his limited insight. These factors may also interfere with accurate psychological evaluation and social diagnosis by conventional methods. Some of the major values of group interaction are that ***diagnostic insights*** may be obtained which the individual is unable to communicate verbally, that he may be enabled to move into more specific rehabilitation activities and helped to dispel attitudes of distrust. The psycho-dynamics of individual behaviour can be studied objectively through direct observation, and new light may be cast on the parent-child relationship and the retarded youngster's potentials. Most important perhaps, the group setting helps to satisfy the "social hunger" of these persons—a hunger less easily satisfied by the one-to-one relationship with an adult therapist. While it is extremely important to the individual to be understood and accepted by a parent or other interested adult, new ingredients are added when a group of individuals share feelings and experiences in a joint search for self-fulfillment.

The potential values of various group services to the trainable have yet to be fully explored and caution must be exercised to guard against indiscriminate use. It has become fashionable among people working in the field of retardation—perhaps because of burgeoning public interest and parental desperation—to plan group programs for

all "trainable" children and adults who are judged ineligible for special education or other community supported social and recreation activities. Unfortunately some of these children are placed in group settings before they are emotionally ready to move from the protective atmosphere of the home into a sometimes frightening environment of strange adults and active children. This lack of selective criteria is bound to be harmful for some individuals or at the very least interfere with the attainment of group goals.

Actually some of the "group" programs currently in effect are lacking many of the elements inherent in the group process. There is little if any interaction between the members and a ***common*** purpose or problem does not emerge. The members look to the group worker rather than to each other for the fulfillment of certain needs. In the absence of this necessary interdependence, communication is slow to develop and the individual's role in the group is poorly defined. When these conditions prevail and group dynamics are relatively inoperative, the true value of the group experience is lost. Group sanctions cannot emerge, social controls are minimized and there is little impact on the behavior, attitudes and values of the members.

In selecting group members, many dimensions of growth and behavior are now applied as single criteria—chronological age, mental ability, social maturity, emotional development, behavior and self-care skills. None of these can stand alone. Categories such as "educable' and "trainable" are not the true entities and static conditions that these terms imply. Whereas the normally intelligent child of three is usually ready for a group experience this may not be true for the trainable retarded child of the same age. Similarly retarded children of ths same age may vary considerably in their abilities, maturity and behavior patterns. Perhaps the concept of ***developmental age*** embodying all of these is the most useful. Grouping children according to their level of social competency and interests may have more merit than grouping them according to age or intelligence. Actually a combination of bio-psychosocial factors must be considered and decisions regarding group participation must rest upon diagnosis of the individual. To make such a determination a thorough interdisciplinary evaluation to which the social group worker can contribute significantly will often be necessary. Safeguards of this kind are essential for meeting the differential needs of retarded persons through social group work or through other methods when the use of group techniques are contra-indicated.

The moderately retarded are especially in need of opportunities for self-enjoyment and for learning functional skills that will contribute to their social usefulness. Whereas the normal child can be expected to acquire these skills through routine experiences, the retarded child must often be taught how to play and how to develop

creative qualities that will contribute to his sense of independence and fulfillment. Through direct experience with other retarded persons the individual is able to develop a more realistic concept of his handicap and limitations as well as a recognition of the many things he can do in the semi-protective atmosphere of the group setting. He can be encouraged to make decisions and to assume responsibility for his behavior, thus promoting his independence and reducing the need for parental supervision.

The mildly retarded

The considerations noted above apply to the mildly retarded child who is not yet ready for school or is no longer attending because of age, educational saturation or discontent with the school program. It applies too, to the emotionally disturbed child and to others needing help in their social adjustment. Identification and recruitment to group programs is often more difficult in the case of these children than in the case of their less capable counterparts. The mildly retarded preschool age child is frequently unknown to social agencies, since he is able to cope with the demands of the home environment and is found wanting only in the competitive, more exacting atmosphere of the school. Equally important, the families of these children, whatever their social-economic status, are often more inclined to rationalize or deny their child's limitations and tend to resist placement of their children in programs designated for "retarded children."

The difficulties in recruiting the mildly retarded to social group work and recreational activities were highlighted in a recent report of a project in Chicago. (51) This report indicated that many of the youngsters were in school and could make a place for themselves in the community—even in employment. Their parents wanted educational rather than play experiences and some were outrightly suspicious of being sought out for services they had been trying to obtain for years without success. Traditional methods of securing applicants through agency referral and coordination, newspaper publicity, interpretive visits to established social institutions, contacts with prospective members, etc., proved somewhat inadequate. Only after a year of operating on a small scale and "word of mouth" advertising from one satisfied client to another did the number of applicants increase significantly. These problems are worth noting, for only as they are understood and community organization techniques adapted accordingly, can this large segment of the retarded population be effectively reached.

The use of the social group work method with the mildly retarded preschool age child, especially those from seriously deprived families, has excellent potentials for correcting and improving the per-

sonality and social adjustment of these children. In many cases it may compensate in some measure for parental inadequacies and serve to accelerate the rate of mental growth of the child beyond the defective range. Though these children are not readily identified outside of the school, their families are often known to social agencies because of financial need, child neglect, delinquency or inadequate child-rearing practices.

It is not suggested that social group work can substitute for physical lacks in the home or that it can determine parental capacities for change and improvement. If it appears feasible to keep these children in the home, however, the group process and the relationship with the worker can make a meaningful contribution not only to the retarded child but to his family as well. Mental and social growth has already been experimentally demonstrated through the use of preschool education techniques (17); there is every reason to believe that structured group activities aimed at the development of proper social conduct and improved interpersonal relationships would have similar effects. The group setting may help the child learn a value system which his own family may acknowledge but fail to promote.

Institutional programs, too, offer exciting prospects for the use of the social group work method. In nearly every State facility there is a sizeable group of mildly retarded adolescents and adults. Many are emotionally disturbed and exhibit conduct disturbances or character disorders. But despite serious adjustment problems, these persons have the best potentials among institutional residents for rehabilitation—providing they receive treatment as well as training.

Probably the least used, yet perhaps the most promising approach with mildly retarded adolescents is that of group treatment through primary use of discussion. Undoubtedly there are many reasons why such programs have been slow in getting started. First, the supply of social group workers skilled in the use of this method is extremely limited and many of those who are skilled in group treatment are not interested in serving the retarded. Second, many institutions stress education and vocational training and underemphasize individual and group treatment. Third, there is still a body of opinion that regards group treatment techniques with the retarded as ineffective.

The last of these assumptions, upon which the other two ultimately rest, has been largely but not entirely refuted. Reports of a few experimental projects suggest that group treatment techniques with the retarded can significantly influence behavior. (52) These studies indicate that the group process can be effective in helping the mildly retarded overcome many of the factors contributing to their institutionalization. Most of the youngsters in these experiments de-

veloped greater skill in their social relationships, a sense of awareness of the needs of others and more desirable personal habits.

These studies further emphasized the importance of size and group composition. For the groups using this treatment approach, the optimal size appeared to be between 6 and 10 members. Children who were known to be unfriendly to each other were generally not placed in the same group and those with uncontrollable anger or lacking even a minimal capacity for group participation and social hunger were excluded altogether. Efforts were made to match the group for age, level of social functioning, emotional maturity and personality characteristics. In this last respect, some balance was considered desirable. Aggressive and submissive children were placed in the same group in order to facilitate expression by some and inhibit the acting-out impulses of others.

These group treatment programs in institutional settings are promising beginnings toward returning the mildly retarded to community life. More experimentation is urgently needed, but it is conceivable that the application of the social group work method with the mildly retarded may extend considerably the range of useful techniques for individuals with difficulties of social adjustment.

Adapting the program

The developmental factors which determine an individual's readiness to participate in structured group activities also bear upon the program selected for him. The fifteen year old youngster with a mental age of six is likely to find activities geared to his mental age too childish, to his chronological age, too complicated. In his size and neuro-muscular development, he is more adult than child. In his social maturity, he may approach either his chronological or his mental age, depending on his previous experiences and the opportunities he has had for self-expression and responsibility.

Awareness of developmental differences within a given individual, and between individuals within a group, is essential to the proper selection of activities and program guidance. The moderately retarded adolescent, for instance, frequently has an impairment of sensory motor coordination. Certain types of physical activity or games will frustrate him and heighten his sense of failure, while similar effects will occur if the rules, thinking or language components exceed his powers of understanding.

These limitations urge caution against applying, without adaptation, program media used with normal children. Actually the range of possible activities is great, including social dancing, games, arts and crafts, music, dramatic plays, story-telling, domestic sciences, and community field trips. But many of these activities when used with the retarded, need to be modified in some respect to

promote intiative, self-confidence and ego development. The conscious direction of these functions and the role of the worker in guiding group interaction, distinguishes these programs from purely social and recreational pursuits.

An important element in social development is success—a particularly crucial factor for the retarded, who characteristically experience so little of it. Structuring the group's activities so that every participant may taste success can help the individual become more secure and confident, less inhibited and withdrawn. In this regard, the organized group offers a unique opportunity to build ego strength in the retarded that is not generally duplicated in the uncontrolled and less protective atmosphere of the home and community. It is important to note, however, that the provision of artificially structured "success experiences" can be carried too far. Failure is as much a part of life as success. In moderation, and at a time when the individual can reasonably cope with it, failure can contribute to healthy personality growth.

Social group workers serving the retarded—whatever the degree of handicap—must be cognizant of these factors and avoid the pitfall of overprotection into which parents so frequently stumble. Though there is real merit in modifying games so that everyone can win and in providing tasks in which all can achieve, the program must be related to the individual's need for success, his capacities for growth and the kind of experiences he may reasonably encounter outside of the group. The child who is constantly overprotected at home may have a better grasp of reality and be better equipped to handle frustration if he fails occasionally, particularly if he is helped to express his frustration constructively. In any event, total protection of the child against failure in the group setting is unrealistic, for it can in no way insure his success elsewhere. The group experience must build self-confidence, it is true, but it must also enhance the retarded child's tolerance for frustration and his capacity to deal with it in a socially acceptable manner.

To promote social competency, activities should be functionally oriented. The moderately retarded youngster is often excluded from various family functions because his social ineptness is a source of embarrassment to his parents. Few have ever attended a theatre, gone to the ball park, eaten at a cafeteria, or shopped independently. Verbal instructions on how to behave in these circumstances generally do not suffice, unless supplemented by detailed and repeated demonstration. The experience itself then becomes meaningful and pleasurable, rather than frightening and painful. It not only broadens the retarded child's understanding of proper conduct and the social milieu in which he lives, but it may also enable him to become a more integral part of family life.

These activities and others (cooking, table manners, sewing, sports) are offered in recreation and education settings as well, and are not social group work per se. They are, however, the *program tools* which the social group worker can use to foster communication and social interaction between individuals whose verbal skills and comprehension are too limited to permit effective discussion. The conscious use of these tools to fulfill the differential needs of retarded children of varying mental abilities are clearly illustrated in an excellent paper by Klein.(53) He points out that informal and imaginative play can help the emotionally withdrawn, inarticulate youngster to express himself and release tension and can provide the worker diagnostic and treatment clues. Games such as follow-the-leader or group singing promote attentiveness, self control and frustration tolerance. Craft work develops muscle coordination, increases interest span, releases tension, familiarizes the retarded with the world of materials and enhances his sense of achievement. Music serves as a medium for emotional expression and group identification, as in chorus or band work, while games stimulate social interaction and, by virtue of rules, teach discipline and self-control. Selectively applied, all of these activities provide the means whereby the low status child can enjoy a more prominent role in the group, the verbally unskilled can communicate and express himself in other ways, the lonely can satisfy his need for companionship, the dependent can become more self reliant.

Social group work techniques with the retarded need not be confined to activity programs. With the mildly retarded at least, especially the emotionally disturbed children from deprived homes, more conventional discussion methods are also applicable. For preadolescents and young teenagers, a combination of activity-discussion sessions seems to be most therapeutic.

Children in institutional care are particularly in need of good socialization experiences and improved human relationships. Separation from the family is often imposed upon them involuntarily with consequent strong feelings of resentment. The structured group program offers an opportunity to act out hostile attitudes and impulses, to reduce feelings of "difference" and to gain insight into one's own symptoms by evaluating the problems of others.

The traumatic background of these children is, as a rule, dramatically reflected in the dynamics of their interaction with each other and with the group therapist. These were analyzed in a project with two therapy groups, reported by Fisher and Wolfson. (54) Early therapy sessions tended to border on the unmanageable. The therapist assumed an extremely permissive approach during this phase, setting limits only with regard to destruction of property and personal injury. The behavior of the children was best described as

"testing the limits." They were threatening and hostile, paid little attention to each other, and competed for the reassurance and acceptance of the leader. As the children became more secure in the leader's acceptance, temporary regression occurred in their eating habits, self care and play patterns. Behavior during this regressive period seemed related to disturbances in family experiences and to the parent-surrogate role of the therapist leader, who ate with the children and in other ways recreated the family structure and relationships. After twelve sessions, the children first began to move from ego-centeredness to group centeredness, to consider the needs of others and to interact in a meaningful manner. Group controls were exerted upon members whose behavior was contrary to group interests and there was less dependency on the therapist than on each other for personal satisfactions. In succeeding phases, continued movement was evident in the development of strong in-group feelings and concern over each others' welfare and behavior. The children were not only concerned with institutional regulations but wanted to learn more about the external community—the lives and habits of children "outside," the kinds of work people did, traffic regulations, property rights, etc. Gradually the group members adopted for themselves a new set of social values and improved standards of personal conduct. They had gained better acceptance of themselves as individuals and now wanted acceptance as a group. The group process had helped to overcome their damaging self-concepts and to pave the way for a socially useful life in the community.

Where group progress was less notable, the reasons seemed to be in the poor selection of members and the small size of the group (4 girls). The submissive children could not exert effective pressure toward the fulfillment of their needs, requiring considerable intervention by the therapist. Moreover, the therapist had failed to remove a member not suited for treatment. In this case group goals were circumvented in some measure by the needs and dominance of a single member.

The social group worker

The functions of the social group worker, whatever techniques may be employed, are to promote the individual's social competence and adaptive behavior. The creative social group worker will adapt program activity and discussion toward this goal. He will provide experiences that will stimulate the individual members to make full use of their faculties to perceive, interpret and remember. He will ensure, to the extent possible, proper amounts of gratification, frustration and protection. He will provide a setting in which retarded individuals can test the physical and social limits of reality and find

successful ways to cope with it. In this process, the retarded may learn what behavior is acceptable and develop the self controls to carry out what they learn.

This obviously places considerable responsibility on the social group worker for direction, guidance and regulation of group dynamics. How active a role the worker must play with a specific group will depend on the member's level of social functioning, which in turn is highly, if imperfectly, correlated with intelligence. With all groups of retarded individuals however, the worker must permit as much self-control, initiative and decision-making as the members are able to assume. These skills develop only in an atmosphere of trust—trust in one's own ability to do, trust that the program will be emotionally satisfying, trust in the worker's acceptance and helpfulness.

To be truly accepting and helpful, the social group worker who would work with retarded children needs additional knowledge derived through education, research and especially practice. He will need to know in greater refinement: which retarded persons can benefit from social group work, and the techniques most appropriate to each subgroup; the relationship of intelligence to group behavior, and to insight and release; criteria for group composition; the optimal length of social and recreational projects or therapeutic clinics; the personal qualifications required in himself.

Knowledge alone does not guarantee acceptance. Basic attitudes are involved—the premium placed on high intelligence, feelings about chronic dependency, the rights and privileges of the handicapped to share in society's resources, the worker's need to see progress in the client. Some workers are unable to fully accept retarded children and this inability shows up in various ways. The worker may deny any capacity for responsibility in the group and be overcontrolling, or deny the fact of retardation and try to make group members over in his own image by pressing them into social situations they cannot handle. Where the expectations and values of the worker are too high and personal needs too great, lack of movement is felt as personal failure and the relationship to the group is necessarily affected.

Not all social workers have the personal equipment to "take" retarded youngsters. The demands on the worker's time and emotional energies differ from the demands experienced with other groups. There is need for exceptional patience, tolerance and understanding, a capacity to accept differences in appearance and the way in which hostility or affection may be expressed, and an ability to accept limited and slower progress. Equally important, especially at this stage of program development, is the need for boldness, flexibility,

imagination, creativity and a willingness to experiment with new activities, program media and techniques.

The magnitude of the task in effectively applying the social group work method to helping the mentally retarded may at first blush seem overwhelming. Yet pioneering efforts of some group service agencies indicate many values for the retarded and their families in the use of this method. These agencies offer a ready crucible in which the crude ingredients affecting the social performance of these persons can be tempered, tested and refined. Through the evaluation of existing services and experimentation with new approaches, further developments may be anticipated.

chapter VI

PLANNING FOR RETARDED CHILDREN

PLANNING FOR THE CARE and training of retarded children occurs at various periods of developmental crises—when the handicap is first recognized or diagnosed, when family stability is threatened or disrupted, when the child enters school, when behavioral problems arise, when he approaches adolescence and its attendant problems, when he enters adulthood with its implications for economic and social self-sufficiency. And the family has its own crises too: the birth of additional children, financial hardship, marital dissension, parental disability or old age. In many families, the problem is not one of acute crises, but of constant adjustment and readjustment.

Each family brings to the crises posed by the retarded child a different set of prior life experiences, perspectives, material and psychological resources. Likewise, each child presents a unique syndrome of problems, needs and potentialities. The interaction of these many variables can and does result in an infinite combination of problems.

The development of a single set of guidelines, therefore, for a population as heterogeneous as the mentally retarded and their families is virtually impossible. Criteria would need to be so broad and general in nature as to provide little direction in their application. The needs of the mildly retarded, culturally deprived child, for example, whose behavior is a source of irritation to the community are quite unlike those of the severely handicapped, organically impaired child whose prolonged and total dependency is largely a family problem. Furthermore, community attitudes and tolerances toward the two groups differ, and these in turn influence the child's concept of himself and how he is perceived by others. This often bears directly on the nature of the parent-child relationship. Clearly, planning for

the former group involves considerations that are not pertinent to the latter, at least not in like degree.

Whatever subcategories are used to differentiate among the retarded—organic, non-organic, mild, moderate, severe—in the final analysis each situation must be carefully individualized. Yet guidelines, while they must be adapted to individual cases, must be established according to the common characteristics and needs of groups. Such guides will not apply to all the retarded children in a specific category all of the time, but they may well be true for most of the retarded, most of the time.

Home Care Versus Institutional Care

The kinds of care children need vary at different stages of child development. What may be necessary and appropriate for the teenager may be quite damaging to the infant and young child. Since the formative years of development are generally the most crucial in an individual's total life experience it may be well to begin where the child himself begins—in infancy—and consider his needs and the criteria to be applied in planning for him.

The parents of a severely retarded infant are faced with a serious dilemma in deciding on the best plan of care. When the condition is diagnosed at birth, they may be advised to place the child in institutional care directly from the hospital and "try to forget him." Should they follow this course of action, they may be severely condemned by relatives for their "heartlessness" or suffer from gnawing doubts about the hastiness of their decision. Actually there are relatively few instances in which a decision regarding placement is of extreme urgency. Most parents want to keep their children at home and need every opportunity to fulfill their sense of parental responsibility. Only as they are convinced that the welfare of the child and other members of the family is best served through placement, can they reach this decision without needless anxiety and guilt.

For the retarded child, as for other children, there is no substitute for an adequate family environment. Numerous studies (12) (55) (56) have demonstrated again and again that children deprived of maternal affection and proper environmental stimulation may be retarded in their intellectual, social and emotional development. Children reared from early childhood in institutions that are overcrowded and understaffed get little fondling and individual attention. As noted earlier, they lag behind in their development in every

dimension—in their language abilities because they are seldom spoken to, in their mental performance because they are neither motivated nor stimulated, in their social skills because of regimentation and lack of normal opportunity for social intercourse.

In a sense, handicapped children need the advantages of family life even more than the normal child, who has a greater inherent capacity to rise above his surroundings. This point may be illustrated simply. Consider two children with *potential* IQ's of 40 and 75, who because of environmental deprivation actually function at IQ levels of 30 and 65. Each has lost 10 points. As a result the first child is now ineligible for special class instruction in many school systems. The second child is now retarded by legal definition in many States and can be admitted for institutional care should his behavior constitute a problem.

Admittedly, quantitative measurements in one area of performance are a poor index for the assesment of environmental impact on development. Yet this highly oversimplified mathematical approach to child development does illustrate what actually can happen to retarded children who fail to realize their full potentials. Abhor as we may, a system that determines a child's future status on the basis of a test score, we cannot ignore the reality of current practice, nor can we minimize the significance of a reduced level of performance.

In planning for the young retarded child, we can say without equivocation that a *satisfactory* family living experience can best meet the child's developmental needs and should be our immediate goal. For most retarded children, early institutionalization is undesirable. Tizard (57) in a summarization of English studies is most outspoken on this point:

> . . . institutional children are particularly retarded in all aspects of language and speech, and in verbal intelligence as compared with similar mentally handicapped children who live at home. The older the children the greater becomes the discrepancy between their achievements and abilities and those of comparable children brought up in their own homes. The same is true of their personal independence. . . . Observation also shows them to be extremely backward socially and emotionally; and it is clear that in these and in other ways institutional care today warps and stunts the development of already seriously handicapped children.

Does this mean that all retarded children—at least for the first few years of life—should remain in their own homes? Is there merit in the current practices of many State institutions that limit admissions to children of four or more years of age? Can institutions for the very young retarded child be eliminated altogether?

The temptation is great to answer all of these questions with a resounding, Yes! But to do so would be to ignore the principle of individualization and to overlook completely the interests of the family. We know that some profoundly retarded children—the progressive hydrocephalic, the severe convulsive disorder, the spastic quadriplegic—may have extensive medical and nursing needs that are beyond the mother's physical energies or the family's financial capacity to provide. Other children—perhaps less retarded—may be so aggressive, hyperactive and destructive that even the highest degree of parental patience and tolerance is insufficient and family stability is threatened. Still others may be so emotionally unresponsive that they offer few gratifications to parents and are potentially destructive to a healthy parent-child relationship.

Maintaining the child in his home at the cost of severe family disruption is not warranted, but the task is first to determine whether such effects are inevitable or are subject to change with professional services. This can only be determined by a thorough interdisciplinary evaluation of the child and a careful psychosocial evaluation of the total family and the many variables affecting its adjustment and adjustability as outlined in Chapter III.

The *interaction* of these factors precludes their application in checklist fashion as a means of predicting what course of action a family may or should take. The factors, however, do suggest certain predispositions which the professional counselor must understand and offer clues regarding the type of plan that certain families would find most acceptable. With this kind of knowledge, we can be more objective about parental motivations, needs and capacities, and be of greater assistance in helping parents decide on the best plan for their retarded child and the other members of the family.

In brief, though we must subscribe to the general principle that the developmental needs of the young retarded child are most likely to be met in his own home, we must also recognize that exceptions occur. In truth, the family that cannot adapt its living patterns to embrace the needs of its retarded member—no matter how adequate it may be adjudged by ordinary standards—should consider placement. A substitute home or even group care may be less damaging than a home characterized by marital tensions and general family disorganization.

As the retarded child grows older and his sphere of activity extends outside the home, community concerns play an increasingly important role in planning. Adolescence is a troublesome period for many youngsters and it is difficult to change the behavior patterns of that small proportion of retarded children who have been exposed to an atmosphere of immorality and antisocial behavior.

In families where this occurs, therapy with the child while

he is in his own home is not likely to be effective, unless parental attitudes and behavior can be properly modified. If they cannot, plans for separation may need to be considered. In some instances—particularly when the youngster's behavior is a serious threat to the community or himself—institutional care may be the best available plan. Some retarded adolescents, despite an extremely negative home environment, are strongly identified with their parents and siblings and would be unaccepting of substitute foster family care. Conversely, foster parents who are willing and able to care for such youngsters are few in number.

An important factor in planning for these youngsters is the nature of their behavior and the degree of protection and supervision they require. A community has greater tolerance for certain types of misconduct than for others. Illegitimacy, for example, is a matter of grave concern to society and the sexually promiscuous girl of retarded intellect may sometimes need to be temporarily segregated until, through a process of character reeducation and supportive therapy, she is able to establish better inner controls over her behavior. Similarly, assaultive behavior may be looked upon as a greater menace than crimes against property. Here too, the protection of the retarded youngster and society may warrant the consideration of institutional placement. Hopefully, these will be regarded as temporary measures and the individual will be returned to community life when he—and his family, if he is going back to them—have been successfully rehabilitated.

Foster Family Care

Institutional care is not the only alternative available to families who lack the essential resources for home care, nor is it usually the most preferred. For the years of early childhood at least, the needs of the retarded child for basic child care are not unlike those of normal children in most instances. Foster parents can frequently provide this kind of care and individual attention.

Unfortunately, foster family placements as treatment resources are used sparingly for retarded children with organic damage, except as a stopgap pending admission to an institution. A primary factor in this is the defeatist attitude some social workers and their supervisors have toward locating foster homes willing to accept such children. Many communities have demonstrated that, with sincere effort, homes for these youngsters can be recruited. More foster parents in-

deed, are willing to accept such children than agencies are to place them!

What are some of the special considerations in foster family care of retarded children? Who are the children most likely to benefit from such care? What criteria can be applied in the selection of foster parents?

Several broad considerations regarding the suitability of children for foster family care can be identified. They relate to his physical condition, mental abilities, behavior, and capacity for interpersonal relationships.

The child who requires close medical supervision or special therapies—and the medical needs of some of the severely handicapped are legion—is more likely to receive this care in a well-staffed residential facility than through the ministrations of foster parents or periodic clinic visits. Furthermore, foster parents should not be expected to assume this kind of responsibility, particularly when there are other children in the home. In these circumstances, demands, which exceed the capacities of natural parents may also be beyond the capacities of foster parents.

Similar considerations apply in lesser degree to the child's behavior. Although the behavior of these children frequently has an organic basis, there is often a functional component as well. Foster parents are less involved emotionally than true parents and, where a more favorable adult-child relationship can be provided, the behavior of brain damaged children sometimes shows marked improvement. These effects are difficult to predict, but unless there are strong indications to the contrary, and management seems highly unfeasible, a trial period in foster care is warranted. Sometimes improvement is considerable and institutional care becomes unnecessary; in other instances the social experiences within the family enable the child to make more constructive use of institutional life, should it be indicated later.

The child's lack of capacity to respond to adult affection and attention, while it may not disquality him for consideration for foster family care, cannot be ignored. Many foster parents—whatever their motivation for this kind of work—derive gratification from the achievements and responsiveness of the children entrusted to their care. When these are denied them and when they cannot accept limited goals, they are ill-equipped to stimulate the child's development or contribute to his sense of security. The sad truth is that parental adequacy toward normal children does not guarantee adequacy in the case of retarded children. Yet there are some foster parents who, through many long years of experience in the care of "problem" children, have acquired a degree of "semi-professionalism"

in meeting the special needs of handicapped children. These parents would have much to offer the relatively unresponsive child.

Foster parents of retarded children need all the personal qualifications—understanding, warmth, consideration of others, emotional stability, security—that all foster parents require, plus some additional qualities. These special characteristics relate not only to the child's mental limitations and its concomitants, but to the wide range of behavior and needs these children present. For this reason, a single, precise profile of the qualifications needed by foster parents of retarded children is unfeasible, though certain generalizations can be meaningful and practical.

Because the retarded child generally lacks the compensatory skills that even many physically handicapped children possess, foster parents must first of all be able to understand and accept the limited capacities of these children. They need a great deal of patience and tolerance in adjusting to a slow rate of maturation and learning, must recognize the need for intellectual stimulation and accept routine and repetition as a necessary teaching technique. Above all, foster parents must be able to accept prolonged and sometimes extreme dependency, and yet at the same time give the child every chance to grow and become responsible. Firmness in discipline, a capacity to guide rather than control, and flexibility in differentiating the retarded child from the normal children in the home are also important characteristics. Equally important is the ability to give of themselves unselfishly and to find emotional gratifications in minor achievements and sometimes a minimum of responsiveness.

Community attitudes also pose problems for the foster parents of these "different" children. To withstand the pressures that can arise, especially in response to "acting-out" children, these parents need a great deal of stability, secure relationships with their neighbors, and a strong conviction of the innate worth of handicapped children.

The identification of these characteristics in foster parents requires careful evaluation. Some of the background and personality factors to be explored are suggested in a study by Fanshel (58). Foster fathers for example, are more successful with aggressive foster children when they have experienced relatively little deprivation in their own childhoods. Some foster families are effective in caring for several types of handicapped children—physical, mental and emotional—and infants with colic as well, all of whom share the essential element of dependency. Most of these successful parents have had the experience of caring for their own children before becoming foster parents. In addition, many come from large, closely knit families, which Fanshel conjectured may provide added social supports to the parents or contribute to the understanding that *all* family members are to be valued. Another important observation, in view

of the long term foster care required by some retarded children, was that the foster parents of handicapped children were more strongly identified with the foster parent role than those caring for normal children.

In selecting a foster home, some thought also needs to be given to the community and its available resources. Are there suitable educational facilities, social and recreation opportunities? Are the social expectations complex or relatively less demanding?

Even when foster parents possess the qualifications outlined above, they cannot be expected to have full knowledge of mental retardation nor to escape the many anxieties that arise. Therefore, the foster parents must be persons who can work in close cooperation with and accept supervision by the agency worker and who are sufficiently secure to seek help as the need arises. Only through a close partnership can full understanding of the special needs of the retarded be approximated.

The careful placement of retarded children in foster family care may have preventive as well as treatment values. With mental stimulation and better cultural opportunities, the deprived retarded child can frequently progress beyond the defective range of intelligence. The organically damaged child may be protected against secondary, but often equally disabling, emotional disturbances. And the older child, whose behavior is marginally acceptable but who needs to learn new way of adaptation, is more apt to find good models for identification in foster parents than in institutional personnel.

Small Group Homes

The use of small agency group homes (generally 7–12 persons) as a resource for retarded children has particular promise for mildly disturbed adolescents and for those needing a transitional, supervised experience to bridge the gap between institutional and community life. These homes offer greater opportunity for individual attention than do large residential facilities and have some of the qualities of interpersonal relationship that characterize family life. In these settings there is less need for regimentation and greater chance for developing social skills through the "parental" guidance of the adult supervisors. Equally important, small group foster homes permit a more selective placement of children according to age, behavior, nature of handicap, special needs and other vital considerations.

When the child's behavior does not exceed community tolerance but his own home is damaging to his welfare and substitute foster

family care is unacceptable or unfeasible, the small group home might be most appropriate. Much depends on whether he needs special training and what prospects exist for early return to his own family or independent placement. Treatment needs may be even more crucial. Does the child have sufficient self-control over his behavior and impulses? Does he need intensive therapy and is it available in the community? Can be profit from a close relationship with adults and intimate living conditions with his peers?

When these questions can be answered affirmatively, the small group home has many advantages as a placement resource for individual retarded children. The adjustment from his own home to this setting is much less complicated than to the strange and artificial environment of the institution. The stigma of commitment to a State institution for retarded persons is avoided. The individual maintains his role as an integrated member of the community and learns new skills in the natural environment in which he must eventually apply them. Furthermore, family contacts with the retarded youngster are more easily maintained (where this is desirable) and professional services more readily coordinated than when social services to the retarded and his family are provided by different agencies or from a distantly located institution.

The "half-way house" is not readily distinguished from the agency operated group home, although it has been used traditionally for individuals released from institutional care rather than as a substitute for institutionalization. While such resources are extremely limited, the need for an intermediate living experience for selected retarded children appears widely accepted. The older adolescent who has been away from the community for years often requires a period of acclimation under continuing supportive help. Adjusting to a new job, finding suitable living arrangements, making friends and learning to use leisure time, is too great a responsibility for some of the retarded to assume all at once. The "half-way house" provides companionship, adult guidance and protection, and reduces the initial task of adjustment to manageable proportions. In time, the retarded individual becomes more independent, extends his scope of activities and personal relationships and is gradually assimilated into the larger community. When this stage of independent living is reached, the semi-protective climate of the "half-way house" is no longer necessary.

Agency-operated group homes and "half-way houses" are new forms of foster care being developed by child welfare agencies and institutions for various groups of children. The stimulus for these developments comes from a better awareness of the differential needs of children and the limitations of traditional methods of care in meeting these needs. Gradually elements of intake, staffing, program and

other considerations in the administration of these facilities are being identified and defined. (59)

Adoption

The advantages to the retarded child of a family living experience may be found not only in his own or a foster home, but in adoptive homes as well. For many years, child placing agencies followed a policy of withholding from adoption infants born out of wedlock to mothers of inferior mental status. Because they believed that these infants were likely to be retarded, or because the child appeared to be slow in his development, they felt that they should hold the child until his mental normality could be established in order to protect the prospective parents. Frequently these infants were placed in emotionally sterile group homes pending later evaluation. Subjected to the depressing forces noted earlier, these children often failed to realize their full potentials and so seemed to support the wisdom of this agency policy.

On the basis of current knowledge that infant psychological testing has questionable value in predicting a child's future potentials and that environmental experiences are important factors in mental growth, this policy is changing. Today, in the absence of gross neuropathology or severe defect, children are placed in adoption as early as possible. This practice is not without its risks, but the greater risk lies in allowing them to remain in culturally deprived environments or denying them individual attention and love. For some, adoptive placement may spell the difference between a lifetime of marginal dependence and social usefulness. As for the prospective parent, there is reason to believe that many parents are willing to accept "less than perfect" children.

While adoption practices are most applicable to the retarded child without pathology, other groups should not be excluded from consideration. Many cases are known of foster mothers or relatives who wish to adopt retarded children who have been placed in their care. If there is full knowledge and acceptance of the child's handicap and the prospective parents are able to provide the child with a suitable home, adoption appears warranted. Sometimes, foster parents are motivated by neurotic needs of their own, but if these patterns are well established and "fit" the child's needs, they are not necessarily harmful. In all of these cases, the social worker and the agency have a weighty responsibility to evaluate the capacities of the prospective parents. And in all cases, the adoptive place-

ment of retarded children should be guided by the same principles, protections and legal safeguards that govern the placement of normal children. (60)

Supplementing Parental Care

Planning for the retarded child and his family, then, starts early in life and rests on the fundamental principle that wherever possible he should be maintained in his natural, substitute or adoptive home. Parents of retarded children are no more able than parents of normal children to meet the needs of their children for education, recreation, socialization and religious guidance—especially since these services are not routinely extended or available to the retarded in many communities. The added responsibility and burden this places on parents cannot be carried by them alone. If the gains to be derived from family living are not to be lost or jeopardized, parental capacities must be supplemented and the child's environment enriched by experiences outside the home.

The stress of caring for the school age retarded child at home is alleviated to some degree when the child is eligible for schooling. Where he is not eligible other programs are needed, including day care, homemaker services, temporary residential care, recreation and even babysitting. Some of these programs are aimed primarily at relieving parents of the overwhelming and sometimes disabling burdens of care and supervision. Others have as their primary objective improving the child's social competency through group learning and interaction. Actually the goals are interrelated, for as the parents are made more adequate and the child's social needs are met, his overall development is enhanced. These programs are effective methods for preserving family unity.

Whatever plan is proposed for a specific child it must be related to his particular needs and level of readiness. This is especially important in determining whether the service should be provided within the home environment, through family day care, or through an outside group.

Day Care

Among the various services that can be used to supplement parental care, care outside the home—for part of the day—is probably the most useful for the largest number of retarded children. The objectives of a day care program are to give care and protection to children whose parents are unable to provide adequate parental

supervision. For the large majority of normal children, the lack of parental supervision stems from the employment of the mother. But many other factors too, while they are not easily assessed quantitatively, interfere with parental capacities to meet the developmental needs of their children. Children may need day care because of illness in the home, the presence of more young children than the mother can find time for, immature parents, behavior problems in the children, and handicapping conditions.

Not the least of these is the last, for the handicapped child—including the mentally retarded—often sorely taxes the physical and emotional energies of the mother to care for him. Even relief from the need for constant supervision of the child for several hours during the day, enabling the mother to organize her household chores, shop, or just rest, can serve as a stabilizing force in family life. Yet this is not the only, or perhaps even the most important, consideration in day care for retarded children. The retarded child, because so few opportunities for peer relationships are available to him and because he is so vulnerable to overprotective or overdemanding attitudes in the home, is particularly in need of developmental and socializing experiences.

The terms "care and protection" in their most literal meaning, actually do not connote the comprehensiveness of day care programs and goals. These have been more clearly expressed in the report of a national conference on day care (61) : "it is more than an educational program, more than safety from physical harm, more than health and sanitation, and embodies the whole child and his family situation. . . ."

These observations suggest that day care is not universally applicable to all children or to all retarded children, and that in each instance, the needs and interests of the child and his parents must be carefully assessed. There are also implications in these remarks for program content, staffing and standards—factors which must be given full consideration if goals are to be met.

Perhaps because of the newness and predominately private sponsorship of day care centers for the retarded, much remains to be done in identifying the kinds of developmental experiences most appropriate to this group, desirable qualifications of personnel, ratio of staff to children, eligibility criteria, and many other considerations embodied in standard setting and licensing procedures. The beginning trend toward the assumption of public responsibility for this program (eight States now provide some public funds for this purpose) has spurred greater activity in this area and promises improved programs.

At the present time, however, there are strong indications in many day care programs that parental needs dominate and sometimes supersede the child's needs. This shows up most clearly in the

inadequacy of intake procedures and the almost complete lack of exclusion criteria. The retarded child who is ineligible for public school attendance is not perforce a suitable candidate for group day care. Some of these children are so frail physically, subject to such severe convulsive disorders, or so aggressive, that their welfare or the safety of others would be endangered in a group setting. Others are too emotionally immature to share the love and affection they need with others, and require so much individual adult attention that their presence in the group tends to deprive others and disrupt the program.

There is widespread acceptance of the principle that most normal children under three years of age are not ready for group day care. The point is hardly debatable for retarded children, since those who are identifiable at this age are generally severely handicapped, have limited communication skills, and function at a one year to eighteen months level, mentally, socially, and emotionally. For these children, if care outside the home is desirable, family day care is a more appropriate plan. Here, too, the home must be selected for a specific child, taking into account the personality and needs of the natural mother and the capabilities of the daytime mother to care for and relate to the child.

Group day care is generally thought to have less widespread application for normal children over 12 years of age, many of whom are capable of looking after themselves. It can, however, serve a highly useful purpose for the adolescent retarded child of severe disability who cannot attend school and is unsuited for occupational training, but who can profit from a recreational, socially-oriented program geared to the promotion of self-care skills and higher social functioning.

In contrast to seriously retarded children, many of the mildly retarded can fit into day care programs for normal children and profit from the relationships thus fostered. The often expressed concern that they will be rejected by the other children or will require an undue amount of supervision, is not borne out by experience. Young children in general do not share adult respect for high intelligence and are relatively free of social prejudices. The likelihood is great that the mildly retarded child will be an accepted member of his group and find greater opportunity for speech and social development than he would if he were placed with others of similar or lesser abilities. The normal child, too, may profit from an appreciation of individual differences and the satisfaction of helping other children less capable than himself. How many retarded children can be absorbed in such groups is still a matter for experimentation, but a ratio of one to five would not seem to present any special stress for either the children or their adult supervisors.

The concepts and principles underlying day care standards for normal children apply to the retarded as well, though some of the standards themselves may need to be modified. For example, day care programs for retarded children usually involve some pre-academic training, but for this group the ratio of children to teachers might need to be smaller than for normal children. The associated physicial defects of these children (some requiring daily medication) may require special attention to health standards, personnel skilled in health supervision or more frequent medical consultation. (62) Some adaptation of play equipment may be necessary for children with difficulties in sensori-motor coordination. Special safety measures may be needed for children especially oblivious to common dangers. Six or eight hours in day care may be too much for many retarded children. Children who cannot walk need less outdoor play space per child. And so on. The development of new standards for this group of children, or the adaptation of existing standards, requires the combined experience, knowledge and training of people in many professional fields.

One additional factor that must be emphasized in day care for retarded children is the importance of casework with their parents. While all such parents do not require this service, the proportion of those who do is large for reasons already stated. The day care program provides, for many retarded children, a whole new range of experiences, some initially frightening and others uplifting. The child is often subjected to different forms of discipline and training than encountered at home and to group pressures he is unaccustomed to. Sometimes this creates inconsistencies in training that confuse the child and further complicate his adjustment. Casework services to the family can prevent such confusion and facilitate continuity between the home and day care center, which will reenforce the learning of desirable habits and skills. Moreover, and equally important, through this service, parents can be helped to resolve feelings and attitudes about the child that hamper his growth potentials.

Homemaker Services

Sometimes it is more feasible to bring services to the child in his own home than to provide them elsewhere, as a means of supplementing parental care and maintaining family unity. Homemaker service is one of the tools social workers and health agencies can use when a retarded child threatens this unity. Unfortunately, this service has not yet achieved the status it deserves and is in very short supply throughout most of the nation. Its application on behalf of retarded children is even more limited.

Considering the many stresses to family life occasioned by a retarded child or stemming from parental inadequacies, as discussed in Chapter III) the value of homemaker services to these families seems self-evident. Crises such as illness or hospitalization of the mother, the birth of a new child, or the mother's death, are often cause for serious family disorganization and institutionalization of the child. In these cases, relatives or friends may be reluctant to provide temporary care for a retarded child and short term foster family care may be unavailable. Furthermore, the parents, knowing full well the problems of care involved, may not feel comfortable about placing their retarded child in a strange environment and depriving him of the security of being with his father and siblings. Bringing the homemaker into the home in these emergencies can insure proper care of the retarded child and enable a mother to devote full-time to her newborn infant. Or it may allow a surviving father and the agency the time needed to work out a satisfactory placement plan or other arrangements. Even where the mother is not ill but needs occasional relief to avoid becoming so, the homemaker can be very helpful. The same is true for families with difficult-to-manage retarded children who cannot be placed in an institution because of long waiting lists.

The homemaker as teacher is no less valuable a tool in strengthening family life. Most parents of retarded children are socioeconomically deprived and some are of limited mentality. Nevertheless, there are often real strengths and warm relationships in these families that can be preserved and put to more effective use. Usually these parents want to give proper care to their children, but they lack the maturity, know-how and, often, the resources to do so. The homemaker, with the supportive help of the caseworker, can teach these parents how to budget, plan meals, market, keep house and care for their children better. With this kind of help, community pressures are reduced and fewer families are broken up because of unintentional child neglect.

The two major functions described briefly above are not mutually exclusive, but each may have primary use with different kinds of family situations commonly encountered in work with retarded children. Administratively, providing for both may be the only way to sustain a homemaker program, especially in rural areas. (63)

Other Services

In discussing guidelines in planning for retarded children, only those services have been considered that are traditionally pro-

vided by social agencies. Obviously many other resources can be utilized which the social worker must know about, make referral to, and help interpret the need for. These include maternal and child health care, social and recreation facilities, occupational training centers, sheltered employment, religious guidance and, of course, special education. All of these contribute ultimately to social functioning and are therefore appropriate resources to be explored by the social worker in helping the retarded child and his family. In some instances, the worker plays a significant role in determining the usefulness of a specific resource for a specific child; in others, the decision rests primarily with another discipline or agency.

Maternal and child health care resources can be particularly helpful to social workers in providing a diagnostic evaluation of the child and recommendation for treatment, particularly in cases involving pathological defect and special medical problems. Without a full understanding of the "whole" child—of which physiological components are an indispensable part—social work treatment goals are apt to prove ineffective. The special clinics for mentally retarded children which have been recently established in almost every State but which are still limited in number, are especially well equipped to contribute to this understanding and to other aspects of interdisciplinary evaluation. (64)

Among the other services noted, the importance of special education is obvious. Probably no other service has more to contribute to the largest number of retarded children than the public school system. But here too, the social worker has much to contribute.

The retarded child—even when he is part of a special class program—is a "different" child in the eyes of the larger student body and the "different" child is often, though not always, a "troubled" child. In the school setting, a mental handicap is apt to set a child apart from other students and create problems of adjustment. Should these conditions prevail unabated, school may become a source of dissatisfaction and truancy, and delinquency or early dropouts may result.

The social worker, in cooperation with the teacher and other school personnel, can contribute to the broad educational and social objectives of the school program. He can make individualization of the child truly meaningful by interpreting to the teacher the emotional climate in the home, the child rearing practices employed, the family's attitudes toward achievement, the cultural values of the community, and many other areas essential to a full understanding of the child's problems. And he can explain to parents the methods which have proven successful in school in matters of discipline, training and management. Through these liaison functions and counseling

services to parents, he may be able to improve the family situation or refer the parents to other appropriate community resources for help.

To carry this responsibility, the social worker must understand the school organization, its structure and policies and its delegation of authority. He should know, too, the laws relating to child education and have a fundamental understanding of the curriculum and its objectives. Fortified by this knowledge, the social worker is better able to pool his resources and skills with the teacher toward enabling the child to use his school experiences to achieve the maximum measure of independence and happiness.

Planning for retarded children is not an exact science. More research and experimentation are needed, diagnostic skills must be sharpened and instruments for evaluation and measurement, refined. The major problem, however, is the lack of resources and facilities and the shortage of skilled professional personnel. Nevertheless, as criteria for meeting individual needs are clarified, we can begin to formulate goals for community action and move toward their achievement.

Community Planning

The development of a community plan to combat the problem of mental retardation must, if it is to achieve long range goals, make effective provision for *prevention* through community services. This is not a responsibility social agencies can carry alone. Nevertheless, the high vulnerability of social agency clientele to the forces which cause or contribute to mental retardation and the overwhelming prevalence of this condition in low income groups, imposes a responsibility which cannot be overlooked. To fulfill this responsibility, the social worker in conjunction with other disciplines and research personnel, must systematically identify and substantiate the family and environmental conditions inimical to child development. Needs must be more effectively interpreted and citizen and legislative support more skillfully sought.

A promising area for prevention lies in the strengthening of basic maternal and child health services. The relationship of low income to dietary deficiencies, prematurity, complications of pregnancy, infectious diseases and mental retardation is firmly established. To avoid as far as possible these potential stresses to maternal health and child growth, the community must see to it that resources for adequate medical care are available. And the social worker must help the parents understand the importance of prenatal care for the mother and pediatric attention for the child and insure that these resources are

used. Close cooperation between the social worker and public health nurse can achieve these objectives in individual cases. Cooperation between health and welfare agencies on local and State levels in promoting public and professional education, disease control and expanded resources, can achieve the same results for the total community.

The prospects for preventing non-organic retardation are also promising. Many of the environmental and psychological variables involved can be controlled, or at least minimized in their effect. Here too, the social worker can apply his skill in strengthening family life, improving child-rearing practices and in providing stimulating opportunities for child growth. But higher level policies of social agencies affecting the welfare of their clients must also be reexamined. Are welfare grants adequate to support basic nutrition and health needs? Do clients know of existing resources and are they located where they are reasonably accessible? Do the laws properly safeguard children from emotional and moral neglect? As solutions to these and other questions are found and social conditions are upgraded, fewer cases of retardation are likely to occur.

The prevention of primary retardation through community services or through research, is but one phase of a preventive program. Where the child is already retarded and his basic condition is irreversible, his overall level of functioning may still be markedly influenced by secondary handicaps of an emotional nature. These are sometimes equally disabling in their impact, but they can be prevented by the skillful application of the various social services already described. To do so with any measure of success however, these individuals must be reached as early in life as possible, before behavior patterns become too well crystallized. This calls for ***early identification*** and skilled case-finding techniques.

Many sources for early case finding exist—private physicians, well-baby clinics, public health nurses, child welfare workers, schools. The problem in many communities is that these sources are not always aware of the potential development of secondary disabilities and fail to invoke the necessary preventive services. Sometimes they have little appreciation of what is needed or where to find it.

To overcome this defect in community planning, organized systems of referral need to be developed. Many possibilities exist, depending on the structure of services in the given community. Information centers are one useful technique—an office identified by parents and professionals alike, as a place to get information on available resources, for help in referral, for literature on the subject, and so on. Social workers have extensive experience in the area of referral and should play a leadership role in this aspect of community plan-

ning, thus enabling retarded children and their families to get to the right agency at the right time.

Systems of referral are effective only as there are resources to refer to and resources that are properly coordinated. In many communities retarded children are compelled to accept second and third choice treatment plans because the first cannot be carried out. One child stays at home because the school has no special classes; another spends years in an institution because foster family care resources have not been developed; a third idles away his time in useless pursuits because he does not meet the qualifications of the agency for training. Sometimes resources are in short supply for all children. More frequently perhaps, restrictive intake policies limit the extension of these services to the retarded.

The dearth of services is not a phenomenon that is unique to the retarded. Other handicapped children are faced with shortages too, and in some communities the normal child fares no better. For all of these children, the community needs to *consciously* plan a network of services and facilities to prevent pathology and to promote the highest level of social usefulness and self-fulfillment in them and their families. To the extent that such planning is comprehensive and embraces the total spectrum of problem situations and the entire range of health, education and social welfare programs, many of the basic needs of the retarded will be met.

This global approach, however, tends to obscure children with special needs. When program limitations are compounded by acute shortages of professional personnel and inadequate financing, agencies tend to set priorities regarding the categories of children to be served. In this process, the retarded child rates low and his parents too, are often denied help. Basic services, ostensibly developed for all children, find limited application, ***yet the extension of basic services is the most effective way for meeting the needs of the retarded.***

Focus on community planning for the retarded can help overcome these discriminatory practices—a need widely recognized in the establishment of special legislative committees, community surveys, and subcommittees of local planning bodies. Concentrated attention to this problem area can stimulate agencies to a reexamination of their policies, identify unused but potential resources, and help set forth those services needed for which no regular provision is made. At the same time, this specialized approach runs the risk of "vertical" planning for different categories of children, duplication of services and uneconomical use of scarce professional staff. These effects can be avoided by centering planning responsibility in local health and welfare councils who are concerned with overall community needs. Viewed as an integral part of the total State and local program for all citizens, the development of programs for the retarded are more likely to gain public support and acceptance.

It is a truism that no single agency or discipline can meet the complex needs of the retarded and that community planning must therefore be a shared responsibility. This highlights the importance of communication between professions and coordination between agencies, factors which rely ultimately on mutual respect, understanding of each others' area of competence and commitment to a common cause.

While no discipline has a "corner" on coordinating techniques, the social worker frequently carries this role. Indeed, social work, which is one of the very few professions that receives special training in this area, seeks to perform an integrating function for which no other provision is made in contemporary society, by enlisting the cooperation of all existing social institutions, facilities and services on behalf of those who need help. This responsibility is carried out through referral procedures, case conferences, community planning and social action and by identifying specific social ills and the need for appropriate remedial and preventive services.

Effective integration of services rests ultimately on the success of community planning efforts, for one can coordinate only what exists. In mental retardation, programs have too frequently been characterized by sporadic and uneven development without full awareness of the relatedness of a given program to total needs. These differences result from the lack of a blueprint for a comprehensive program. Individual children not only are deprived of essential services, but a distinct possibility exists that the benefits of available programs may be minimized.

Before blueprints can be developed—whether for a small rural community or a large industrial State—the diversity of needs must be identified and interpreted. The community must not only know how many retarded persons they have, but must know their outstanding characteristics, the proportion that need service and what kind, and the resources that can be brought to bear on the problem.

The community planning process is an excellent, and indispensable, device for bringing together the agencies, individual workers and lay citizens who represent the essential interrelated parts and interests underlying a comprehensive program. Of the lay representatives, the delegate from the local or State parent group is often the most important. These groups are in the vanguard of public education programs and are a potent force in stimulating legislative action, supporting research, and sponsoring pilot demonstration projects. Their specialized character and intense motivations—properly harnessed—can be a spur to progress. Through dynamic interaction with the professional community in the planning process, better understanding of one another may be achieved. In this way, the total community is able to move toward commonly defined goals.

Agencies are able to reflect on what they are doing or can do with additional staff and budget, and priorities for action can be formulated. When, however, parents and professionals do not communicate and negotiate where necessary, resistances often arise that hinder effective planning or the implementation of a specific program.

Each community has a unique personality as reflected in its overall organization of programs, prevailing social philosophy, size of population, economic and cultural condition, and attitudes toward the retarded. For this reason, each may face somewhat different problems, though many similarities undoubtedly exist. For example, the number of severely handicapped children in a relatively small town may be too small to warrant setting up a day care center. Or a sheltered workshop may not be feasible in a small community or one lacking industrial resources. In both of these instances, some other type of program may be necessary. The important consideration is not to overlook the needs of these groups and to experiment with new ways of meeting them.

Each community too, while its long range goals may be similar, may set different priorities for immediate fulfillment. Various factors are involved such as community readiness to accept and support a new program, availability of staff, and financial aspects. How many persons need the service is less important than how many would actually use it were it available. Parent interest and attitudes, or practical obstacles in using the service, need to be assessed in the planning stages. Here too, the social worker has much to contribute.

One of the major factors to be considered by community planners is cooperation and coordination between local and State services. Many local communities lack the fiscal capacity to support certain programs which may be more costly for retarded than for non-retarded children. Special education is a good example, but many other illustrations are possible, such as day care, diagnostic services, sheltered workshops. Some services can be provided on a regional basis, involving the cooperation or joint sponsorship of several communities, but others must be provided where the individual lives and may call for partial State subsidy. No set pattern would apply to every State or community, but local planners should be familiar with State resources in order to make maximum use of them.

Another consideration in planning relates to research, and the evaluation of existing services. Not every community can undertake basic research, but all should recognize the importance of testing the efficiency of programs, experimenting with new techniques and discarding programs that achieve no useful purpose. Finally, the success of any community program rests ultimately on the knowledge, skill and understanding of those responsible for the provision and administration of services. If the retarded are to be integrated to

the highest degree possible in existing programs, then the professional staff involved must be trained accordingly. In-service training and educational opportunities in institutions of higher learning must therefore be an integral part of the community plan.

The task confronting many States and communities in providing for the retarded child and his family the services needed, is great. But the task is not impossible, and significant progress is being made. In time, we may realize the goals expressed by the World Health Organization: (65)

> Every child has the right to expect the greatest possible protection against the occurrence of preventable physical handicap before, during, and after his birth.
>
> Every child also, regardless of the nature of his physical handicap, has the right to develop to the maximum of his abilities, in spite of his disablement. This implies that the child with a physical handicap should have ready access to the best medical diagnosis and treatment, allied preparation, and employment. In this way he should be able to satisfy the needs of his own personality to the maximum, and become as far as possible a useful and independent member of the community.

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